

## Reg. Dist. No. 02

2081382XV5

VS A15 (4)  
15M 9/55

# CERTIFICATE OF DEATH

STATE OF MARYLAND

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

ATTEST

SIGNATURE

DATE

PLACE

STATE

COUNTY

CITY

BUREAU V. 2

NOV 8 1956

RECEIVED

NOV 8 1956

ANDREW K. GOLLIN

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11805 CERTIFICATE OF DEATH

11787  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>HARVEY</u> Last <u>BAHM</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 27, 1887</u>		9. AGE (In years last birthday) <u>69 yrs.</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Pub. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Bahm</u>				14. MOTHER'S MAIDEN NAME <u>Alice Mc Morrow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W. W. I 214-09-2196</u>		17. INFORMANT <u>Charles J. Bour</u> Address <u>Blue Ridge Summit, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of head of pancreas</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>157X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 3, 1956</u> , to <u>Nov. 16, 1956</u> , that I last saw the deceased alive on <u>Nov. 15, 1956</u> , and that death occurred at <u>12:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George Jennings</u>				ADDRESS (Street, city or town, state) <u>136 W. Washington St. Hagerstown, Md.</u>		DATE SIGNED <u>11/17/56</u>	
PHYSICIAN'S NAME (Type) <u>George Jennings, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Inter-Houzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 17, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1956 67 Nov.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11788

## 11853 CERTIFICATE OF DEATH

Reg. Dist. No.

307

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrotts Mills</b>			c. LENGTH OF STAY IN 1b <b>83 years</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -			d. STREET ADDRESS -		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Anna</b> First <b>Levenia</b> Middle <b>Beamer</b> Last			4. DATE OF DEATH Month <b>II</b> Day <b>7</b> Year <b>1956</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-26-1873</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Warren Pendelton</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Clara Smothers, Knoxville, Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility</b> <b>794X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. <b>11</b> p. m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1-1-1956</b> to <b>11-7-1956</b> that I last saw the deceased alive on <b>11-7-1956</b> , and that death occurred at <b>2:15 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Brunswick, Md.</b> DATE SIGNED <b>11-9-56</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>Brunswick, Md.</b>					

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-10-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley</b>		22d. LOCATION (City, town, or county) (State) <b>Garrotts Mills Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>				ADDRESS <b>Brunswick, Maryland</b>		24a. REC'D BY REGISTRAR <b>[Signature]</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				24c. DATE <b>11-9-56</b>			

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		TREATMENT	
HISTORY		FAMILY HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATION	
PATHOLOGICAL FINDINGS		MICROSCOPIC FINDINGS	
GROSS FINDINGS		HISTOLOGICAL FINDINGS	
DIAGNOSIS		TREATMENT	
PROGNOSIS		FOLLOW-UP	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

NOV 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11854 CERTIFICATE OF DEATH

11789

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonesboro</u>		c. LENGTH OF STAY IN TB <u>11 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>		d. STREET ADDRESS <u>1201 Hamilton Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Herma</u> Middle <u>Naomi</u> Last <u>Biershing</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1883</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stationery Store Near Rohrsersville Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>George Biershing</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Geltmacher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>214-09-1683</u>	
17. INFORMANT <u>Dr. Clifford Luke</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>  </u> yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>11-12-56</u> , 19 <u>  </u> , to <u>11-13-56</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>11-12-56</u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis G. Gray</u>		ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>11-14-56</u>	
PHYSICIAN'S NAME (Type) <u>Louis G. Gray, M.D.</u>		<u>Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. S.

NOV 19 1956

RECEIVED

NAME OF DECEASED <b>George Elmer</b>		DATE OF DEATH <b>Dec 22 1953</b>
AGE <b>68</b>		SEX <b>M</b>
RACE <b>White</b>		EDUCATION <b>High School</b>
BIRTH DATE <b>Dec 22 1885</b>		PLACE OF BIRTH <b>Rockville, Md.</b>
OCCUPATION <b>Electrician</b>		CAUSE OF DEATH <b>Heart Disease</b>
RESIDENCE <b>1234 Elm St., Baltimore, Md.</b>		DATE OF REPORT <b>Dec 23 1953</b>
REPORTED BY <b>Dr. J. H. Smith</b>		SIGNATURE OF REPORTER <i>[Signature]</i>
CERTIFICATE NO. <b>12345</b>		FILE NO. <b>68-12345</b>

## 11805 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>2 Days</b>		d. STREET ADDRESS <b>27 No Walnut St</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM ----- BISHOP</b>		4. DATE OF DEATH Month Day Year <b>November 19 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19 1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Sidling Hill Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Freeman Bishop</b>		14. MOTHER'S MAIDEN NAME <b>Edith Lamm</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No -----</b>		16. SOCIAL SECURITY NO. <b>219-05-2131</b>	
17. INFORMANT Address <b>Mrs Annie E. Bishop 27 So. Walnut St</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Hagerstown Md</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331x Cardiovascular collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vas. Accident</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>4 up</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 18, 1956</b> , to <b>Nov 20, 1956</b> that I last saw the deceased alive on <b>Nov 19, 1956</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis S. Graff</b>		DATE SIGNED <b>11/21/56</b>	
PHYSICIAN'S NAME (Type) <b>Louis E. Graff MD.</b>		<b>Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Beaver Creek Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov. 23. 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bowers</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. E.

1956 50 100.

RECEIVED

1.  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

## 11807 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>45 1/2 West Franklin Street</u>		d. STREET ADDRESS <u>45 1/2 West Franklin Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROSCOE</u> Middle <u>SCHINDEL</u> Last <u>BOWARD</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. UNDER 1 YEAR Months <u>8</u> Days <u>3</u>	11. IF UNDER 24 HRS. Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Dealer</u>	11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Boward</u>		14. MOTHER'S MAIDEN NAME <u>Jane Koon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-09-7960</u>	17. INFORMANT <u>Mrs. Mary Boward Hagerstown, Maryland</u>
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 9</u> , 19 <u>56</u> to <u>Nov 10</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Nov 10</u> , 19 <u>56</u> , and that death occurred at <u>11 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Maryland</u> DATE SIGNED <u>11-10-56</u> ACTUAL SIGNATURE <u>S. DNEY</u> M.D. <u>NOVENSTEIN</u> PHYSICIAN'S NAME (Type) <u>S. DNEY NOVENSTEIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/12/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Franklin Rieger</u>		ADDRESS <u>Hagerstown, Md.</u>	24a. REC'D BY REGISTRAR <u>Nov 13 1956</u>
		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Form 100-10-1

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		JUNE 10 1968	
AGE		SEX	
35		Male	
RACE		EDUCATION	
White		High School	
OCCUPATION		MILITARY SERVICE	
None		None	
PLACE OF BIRTH		CITY OF BIRTH	
Memphis, Tennessee		Memphis, Tennessee	
DATE OF BIRTH		PLACE OF DEATH	
May 17 1933		Memphis, Tennessee	
CAUSE OF DEATH		MANNER OF DEATH	
Suicide by hanging		Accident	
DISEASE OR INJURY		TOXIC SUBSTANCE	
None		None	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
None		None	
DATE OF SIGNATURE		DATE OF SIGNATURE	
None		None	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
None		None	
NAME OF REGISTRAR		NAME OF REGISTRAR	
None		None	
DATE OF REGISTRATION		DATE OF REGISTRATION	
None		None	
PLACE OF REGISTRATION		PLACE OF REGISTRATION	
None		None	

BUREAU V. 4

10V 15 1956

RECEIVED

## 11808 CERTIFICATE OF DEATH

11792  
Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Nursing Home</u>		d. STREET ADDRESS <u>905 Potomac Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Belie Irene Bowers</u>		4. DATE OF DEATH Month Day Year <u>Nov. 1 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswomen</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Bridgeport Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George W. Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Flora</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>195-07-0598</u>	
17. INFORMANT Address <u>Miss Llewella M. Bowers Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis (2nd Cerebral Hemorrhage)</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes - Chronic Myocarditis</u> DUE TO (c) <u>Neurophlegia Cerebralis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>24 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 13, 1946</u> , to <u>Nov 1, 1956</u> , that I last saw the deceased alive on <u>Oct. 27, 1956</u> , and that death occurred at <u>2:30 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>145 W Washington St Hagerstown Md 11/2/56</u>			
ACTUAL SIGNATURE <u>W D Campbell</u> M.D.			
PHYSICIAN'S NAME (Type) <u>W D CAMPBELL M.D.</u> <u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 4, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>		24a. REC'D. BY REGISTRAR <u>Nov 5, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>W D Campbell</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>George W. Roberts</b>		2. SEX <b>Male</b>	
3. AGE <b>65</b>		4. DATE OF BIRTH <b>1871</b>	
5. PLACE OF BIRTH <b>St. Louis, Mo.</b>		6. OCCUPATION <b>Chemist</b>	
7. MARITAL STATUS <b>Married</b>		8. DATE OF DEATH <b>Nov 1956</b>	
9. CAUSE OF DEATH <b>Heart Disease</b>		10. PLACE OF DEATH <b>Home</b>	
11. SIGNATURE OF PHYSICIAN <b>George W. Roberts</b>		12. SIGNATURE OF WITNESSES <b>George W. Roberts</b>	

BUREAU V. 1

NOV 2 1956

RECEIVED



## 11855 CERTIFICATE OF DEATH

Reg. Dist. No.

301

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md RFD #1</b>		c. LENGTH OF STAY IN b <b>18 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Maryland RFD #1</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Downsville Md.</b>	
d. STREET ADDRESS <b>Downsville Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Catherine</b> Last <b>Bowers</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5 1875</b>
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Williamsport Md RFD</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Christian Metz</b>	
14. MOTHER'S MAIDEN NAME <b>Prudence Thomas</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Charles Bowers</b> Address <b>Williamsport Md RFD #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, from leg</b> <b>454X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial thrombosis, left leg</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>6 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Vascular Accident</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b></b>		(County) (State)	
21. I certify that I attended the deceased from <b>Oct 2</b> , 19 <b>56</b> , to <b>19 Nov</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>19 Nov</b> , 19 <b>56</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul Haak</b>		ADDRESS (Street, city or town, state) <b>2800 Patomac Street</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HAACK M.D.</b>		DATE SIGNED <b>20 Nov 56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 22-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>
22d. LOCATION (City, town, or county) <b>Bakersville Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith V. Leaf</b>		ADDRESS <b>Williamsport</b>	
24a. REC'D BY REGISTRAR <b>Nov 21-56</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		APR 4 1968		MEMPHIS, TENN.	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE		MARRIAGE PLACE		EDUCATION		OCCUPATION	
JAN 19 1933		MEMPHIS, TENN.		JAN 19 1957		MEMPHIS, TENN.		HIGH SCHOOL		PUBLISHER	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DECEASED'S RELIGION		DECEASED'S POLITICAL PARTY	
JAMES EARL RAY		LUCILLE RAY		PUBLISHER		HOUSEWIFE		METHODIST		DEMOCRAT	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		UNDERLYING CAUSE		DECEASED'S SIGNATURE		WITNESSES' SIGNATURES	
HEART DISEASE		NATURAL		CORONARY THROMBOSIS		CORONARY ARTERY DISEASE		JAMES EARL RAY		JAMES EARL RAY	
DECEASED'S SIGNATURE		WITNESSES' SIGNATURES		DECEASED'S SIGNATURE		WITNESSES' SIGNATURES		DECEASED'S SIGNATURE		WITNESSES' SIGNATURES	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 2

JUN 23 1968

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

11794  
307

11856

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Williamsport</u> 50 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Williamsport</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport RFD # 2</u>				d. STREET ADDRESS <u>Williamsport RFD#2</u>			
3. NAME OF DECEASED (Type or print) First <u>IVY</u> Middle <u>MYRTLE</u> Last <u>BRILLHART</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>14</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>(First not known) Corderman</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lloyd Brillhart</u>		Address <u>Williamsport RFD #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>11/27/56</u> to <u>11/28/56</u> , that I last saw the deceased alive on <u>11/28/56</u> , 19 <u>56</u> , and that death occurred at <u>130</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph Young</u> M.D.				DATE SIGNED <u>11/29/56</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Clearspring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 29-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>E Lee McBrody</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Doe		45		Male		White		Jan 1, 1956		Home		Heart Disease		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of Funeral Home		Signature of Burial Place	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

DEC 3 1956

RECEIVED

## 11809 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. Y.</u> b. COUNTY <u>Brooklyn</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> 69X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Memorial Hospital</u>				d. STREET ADDRESS <u>140 Quentin St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>A</u> Last <u>CHAMBERS</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 24, 1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>90</u> Days <u>90</u> Hours <u>90</u> Min. <u>90</u>		IF UNDER 24 HRS. Months <u>90</u> Days <u>90</u> Hours <u>90</u> Min. <u>90</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Jonas Spencer Dodge</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Martyn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Gertrude C. Rice</u>		17. INFORMANT <u>Brooklyn N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> <u>420.0</u> DUE TO <u>with myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>1956</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1 Feb</u> , 19 <u>56</u> , to <u>18 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 Nov</u> , 19 <u>56</u> , and that death occurred at <u>145 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N. Potomac St</u>		DATE SIGNED <u>18 Nov 56</u>	
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				M.D. <u>Hagerstown Md</u>			
22a. BURIAL-CREATION REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Nov. 21, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	
22d. LOCATION (City, town, or county) <u>Washington D.C.</u>				(State) <u>D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lee's Son Co.</u>				ADDRESS <u>300 4th St N.E.</u>		24a. REC'D BY REGISTRAR <u>DATE 11-22-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Barnes</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES HENRY HARRIS		M		45		1911		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		1956		BALTIMORE		MD		MD		USA	
FATHER'S NAME		MOTHER'S NAME		SPOUSE'S NAME		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
JAMES HENRY HARRIS		MARY ANN HARRIS		JANE HARRIS		1935		BALTIMORE		MD		MD		USA	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE	
11/15/56		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

NOV 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11810 CERTIFICATE OF DEATH

11796

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1101 Woodland Way</u>		d. STREET ADDRESS <u>10 West Oak Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>KATIE</u> Middle <u>LOIS Lewis</u> Last <u>COLVIN</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 15, 1867</u>
9. AGE (In years lost birthday) yrs. <u>89</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary K. Cash</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Howard T. Colvin</u>		Address <u>Alexandria, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 26, 1956</u> , to <u>Nov. 27, 1956</u> , that I last saw the deceased alive on <u>Nov. 26, 1956</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. A. Bell</u>		ADDRESS (Street, city or town, state) <u>119 N. Potomac Street</u>	
PHYSICIAN'S NAME (Type) <u>R. A. Bell, M. D.</u>		DATE SIGNED <u>11-28-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/30/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Alexandria, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Poyner</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov. 28, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas H. Bowers</u>	

BUREAU V. S.

1056 38 NOV

RECEIVED

## 11811 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>421 East Sumner Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Rev) <b>CHESTER</b> First <b>MILTON</b> Middle <b>COMER</b> Last		4. DATE OF DEATH <b>Nov 7 1956</b> Month <b>Nov</b> Day <b>7</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 4 1906</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Rev Charles P Comer</b>	
14. MOTHER'S MAIDEN NAME <b>Hattie Ross</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>----</b>	
16. SOCIAL SECURITY NO. <b>Civil Service Mrs Elsie M. Comer</b>		17. INFORMANT Address <b>421 Sumner Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>345X</b> DUE TO <b>Multiple Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) <b>Arteriosclerosis, Phlebotomy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>2 yrs.</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 19 1956</b> to <b>Nov. 7 1956</b> , that I last saw the deceased alive on <b>Nov 27 1956</b> , and that death occurred at <b>530 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		DATE SIGNED <b>11/7/56</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-10-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Mem Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md</b>	
24a. REC'D BY REGISTRAR <b>Nov 9 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH MAY 1928		PLACE OF BIRTH MONTGOMERY, MARYLAND	
RESIDENCE 1101 BROAD STREET AVE		OCCUPATION CONTRACTOR		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH MAY 1968		PLACE OF DEATH BALTIMORE, MARYLAND		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF CORONER JAMES EARL RAY		SIGNATURE OF REGISTRAR JAMES EARL RAY	

BUREAU V. 3

NOV 13 1968

RECEIVED

NAME OF PHYSICIAN JAMES EARL RAY		NAME OF CORONER JAMES EARL RAY		NAME OF REGISTRAR JAMES EARL RAY	
SIGNATURE OF PHYSICIAN JAMES EARL RAY		SIGNATURE OF CORONER JAMES EARL RAY		SIGNATURE OF REGISTRAR JAMES EARL RAY	



11812

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>2 Mos</b>				d. STREET ADDRESS <b>426 George St</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ROY CORDER</b>				4. DATE OF DEATH Month Day Year <b>Nov 23 1956 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feby 11 1890</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinists Helper W.M.R.R. Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Brownsville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jackson Corder</b>				14. MOTHER'S MAIDEN NAME <b>Martha Hahn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>705-10-5964</b>		17. INFORMANT Address <b>Mrs Hattie M. Corder 426 George St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6-7 day</b> <b>Unknown</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lobes pneumonia</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec 13</b> , 19 <b>55</b> , to <b>Nov 22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 22</b> , 19 <b>56</b> , and that death occurred at <b>11:20</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. L. Packer, Jr.</b> M.D. <b>1145 W. Washington St.</b> <b>11-23-56</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>L. L. Packer, Jr., M. D.</b> <b>Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> <b>Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 26 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 2

NOV 28 1956

RECEIVED

Andrew K. Collins Bakerstown Md.

HOME HILL CEMETERY

MD 21011

Bakerstown, Md.

11/28/56

1956

11/28/56

11813

## CERTIFICATE OF DEATH

Dr B.B.Kneisley  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>63 East Ave</b>				d. STREET ADDRESS <b>63 East Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LUTIE</b> Middle <b>BELL</b> Last <b>DELLINGER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25 1880</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>near Downsville Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cyrus Dellinger</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth J. Winter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Margaret D. Kretsinger</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>10 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Nov. 14</b> , 19 <b>56</b> , to <b>Nov. 20</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 20</b> , 19 <b>56</b> , and that death occurred at <b>9:40P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>148 West Washington Street Hagerstown Wash. Co Md.</b> DATE SIGNED <b>11/21/56</b>							
ACTUAL SIGNATURE <b>B. B. Kneisley</b>				M.D. <b>148 West Washington Street Hagerstown, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 23, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blanch Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		40		1915		Baltimore		Maryland		United States		United States	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION	
1956		10:00 PM		Home		Heart Disease		Natural		Teacher		High School		Roman Catholic	
DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		CITY		STATE		COUNTRY		CITY		STATE	
1956		10:00 AM		St. Mary's Cemetery		Baltimore		Maryland		United States		Baltimore		Maryland	
NAME OF FUNERAL HOME		ADDRESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
J. J. Harris		1234 Main St.		Baltimore		Maryland		United States		Baltimore		Maryland		United States	
NAME OF PHYSICIAN		ADDRESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
Dr. J. J. Harris		1234 Main St.		Baltimore		Maryland		United States		Baltimore		Maryland		United States	
NAME OF CORONER		ADDRESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
J. J. Harris		1234 Main St.		Baltimore		Maryland		United States		Baltimore		Maryland		United States	
NAME OF BURIAL PLACE		ADDRESS		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
St. Mary's Cemetery		1234 Main St.		Baltimore		Maryland		United States		Baltimore		Maryland		United States	

BUREAU V. S.

NOV 26 1956

RECEIVED

Andrew K. Goldman, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 208 12-12-56 ams

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

11800

11857

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>N. MAIN ST.</u>		d. STREET ADDRESS <u>N. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET GRAHAM DITTO</u>		4. DATE OF DEATH <u>NOVEMBER - 26 - 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 18 - 1863</u>
9. AGE (In years last birthday) <u>43-58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>SOUTHAMPTON</u>		12. CITIZEN OF WHAT COUNTRY? <u>ENGLAND</u>	
13. FATHER'S NAME <u>WILLIAM GRAHAM</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET (no record)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FREDERICK K. DITTO</u>		Address <u>BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolized cardiac sclerosis</u> 902.0 DUE TO (b) <u>Fractured hip -</u> DUE TO (c) <u>Fractured hip -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>11 mon</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Got out of bed and fell</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>Nov. 26</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Boonsboro</u> <u>Wash</u> <u>MD</u>	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Nov. 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 26</u> , 19 <u>56</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. LeVan</u>		ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>11/28/56</u>	
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 29, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR CLEARSPRING, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		ADDRESS <u>BOONSBORO MD</u>	
24a. REC'D BY REGISTRAR <u>Nov 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. East</u>	



BUREAU V. S.

DEC 3 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11801

Reg. Dist. No. 307

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Washington</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Washington</span>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rohrersville</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">Life</span>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Rohrersville</span>															
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">None</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">Main Street</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around;"> <span>First <span style="font-size: 1.2em;">John</span></span> <span>Middle <span style="font-size: 1.2em;">Milton</span></span> <span>Last <span style="font-size: 1.2em;">Easton</span></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around;"> <span>Month <span style="font-size: 1.2em;">Nov.</span></span> <span>Day <span style="font-size: 1.2em;">21</span></span> <span>Year <span style="font-size: 1.2em;">19 56</span></span> </div>															
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">April 10, 1905</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">51 yrs.</span>	<b>IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;"></span> Days <span style="font-size: 1.2em;"></span>	<b>IF UNDER 24 HRS.</b> Hours <span style="font-size: 1.2em;"></span> Min. <span style="font-size: 1.2em;"></span>												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Rohrersville</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>													
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Benjamin Franklin Easton</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Alberta Reeder</span>															
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">none</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Mrs. Benjamin Easton- Rohrersville, Md.</span>															
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Acute Coronary Occlusion</span>  <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">420.1</span> <span><b>DUE TO</b></span> </div> <span style="font-size: 1.2em;">Epilepsy</span> </td> <td colspan="2" style="padding: 5px; vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>     </td> </tr> <tr> <td colspan="4" style="padding: 5px;"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <div style="display: flex; justify-content: space-between;"> <span>(b)</span> <span><b>DUE TO</b></span> </div> </td> </tr> <tr> <td colspan="4" style="padding: 5px;"> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  <span style="font-size: 1.2em;">Mentally retarded</span> </td> </tr> </table>								<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Acute Coronary Occlusion</span> <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">420.1</span> <span><b>DUE TO</b></span> </div> <span style="font-size: 1.2em;">Epilepsy</span>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>   		<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <div style="display: flex; justify-content: space-between;"> <span>(b)</span> <span><b>DUE TO</b></span> </div>				<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <span style="font-size: 1.2em;">Mentally retarded</span>			
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Acute Coronary Occlusion</span> <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">420.1</span> <span><b>DUE TO</b></span> </div> <span style="font-size: 1.2em;">Epilepsy</span>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>   																	
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <div style="display: flex; justify-content: space-between;"> <span>(b)</span> <span><b>DUE TO</b></span> </div>																			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <span style="font-size: 1.2em;">Mentally retarded</span>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">None</span>																	
<b>20c. TIME OF INJURY</b> Month, Day, Year <div style="display: flex; justify-content: space-around;"> <span>Hour <span style="font-size: 1.2em;">None</span></span> <span>a. m. <span style="font-size: 1.2em;">19</span></span> </div>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">none</span>		<b>20f. (City or town)</b> (County) (State) <div style="display: flex; justify-content: space-around;"> <span><span style="font-size: 1.2em;">-</span></span> <span><span style="font-size: 1.2em;">-</span></span> <span><span style="font-size: 1.2em;">-</span></span> </div>													
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em; font-family: cursive;">S. Robert Wells</span>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <span style="font-size: 1.2em;">11-23-56</span>													
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">S. Robert Wells, M.D.</span>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>													
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">11-23-56</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Rohrersville</span>		<b>22d. LOCATION (City, town, or county)</b> (State) <span style="font-size: 1.2em;">Rohrersville Md</span>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">BOST FUNERAL HOME</span>				<b>ADDRESS</b> <span style="font-size: 1.2em;">BOENS130120 MD</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">NOV 23 1956</span>													
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.5em; font-family: cursive;">Katherine Sagenhart</span>																			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

**BUREAU V. 5**

1056 55 105

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Hirshman

11802

11814

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>6 Yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>405 Ridge Ave</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>405 Ridge Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAURICE ELMER FISHER</b>				4. DATE OF DEATH Month Day Year <b>November 2 1956 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 12 1878</b>	
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hag Rubber Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Clay Hill Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Sanford E. Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Pryor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-7245</b>		17. INFORMANT <b>Mrs Sareh M. Fisher</b>		Address <b>405 Ridge Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis Sclerolyzed</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 minute</b> <b>3 years</b> <b>3 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown Md.</b>				20g. (County) <b>Hagerstown</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Feb. 2 1956</b> to <b>Nov 2 1956</b> , that I last saw the deceased alive on <b>Dec 31 1956</b> , and that death occurred at <b>9:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				DATE SIGNED <b>11/2/56</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 6. 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>B. H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 8 AUG

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11815 CERTIFICATE OF DEATH

11803

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>67 EAST AVE.</b>				d. STREET ADDRESS <b>67 EAST AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>CLARENCE</b> Last <b>FRANK</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>3</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/1890</b>		9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEET METAL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN H. FRANK</b>				14. MOTHER'S MAIDEN NAME <b>MARY BERRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>W.W.#1 440-01-6518</b>		17. INFORMANT <b>MRS. RUTH G. FRANK</b> Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b>Generalized arterio-sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 3</b> , 19 <b>55</b> , to <b>Nov 3</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 3</b> , 19 <b>56</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sidney Novenstein</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>Nov 11-56</b>			
PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CH. CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON COUNTY MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Norment, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov. 7. 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

10V 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11804

11859 CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN b <u>YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY MEMORIAL HOME</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>FREDERICK</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u> RURAL d. STREET ADDRESS <u>JOHNSVILLE</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH HIBERT FROUNFELTER</u>				4. DATE OF DEATH Month Day Year <u>NOV 21 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 6 - 1870</u> 85 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - RETIRED - TENANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U. S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				13. FATHER'S NAME <u>NOAH FROUNFELTER</u>			
14. MOTHER'S MAIDEN NAME <u>LOUISEA ENGELMAN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>CHAS. FROUNFELTER, UNION BRIDGE MD.</u>			
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Benign atherosclerosis</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute angina -</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10yrs</u> <u>1hr.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 5</u> , 19 <u>56</u> , to <u>Nov 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>56</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. L. L. L.</u> M.D. <u>Boonsboro</u>				ADDRESS (Street, city or town, state) <u>Boonsboro</u>			
PHYSICIAN'S NAME (Type) <u>G. W. L. L. L.</u>				DATE SIGNED <u>11/21/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HAUGHS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>LADIESBURG MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler &amp; Sons Union Bridge, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 26 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>John F. Rust</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]		PLACE OF BIRTH [Faint handwritten place]	
OCCUPATION [Faint handwritten occupation]		MARITAL STATUS [Faint handwritten status]		EDUCATION [Faint handwritten education]	
PREVIOUS ILLNESS [Faint handwritten illness]		MEDICAL HISTORY [Faint handwritten history]		SURVIVAL OF SURVIVORS [Faint handwritten survivors]	
SIGNATURE OF DECEASED [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF JURY [Faint handwritten signature]		SIGNATURE OF JUDGE [Faint handwritten signature]	

BUREAU V. S.

NOV 03 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11816

## CERTIFICATE OF DEATH

11805

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1028 SPRUCE ST.		d. STREET ADDRESS 1028 SPRUCE ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES ALEXANDER GILKEY		4. DATE OF DEATH Month Year Day 6 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1876
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WORKER		10b. KIND OF BUSINESS OR INDUSTRY SHOE FACTORY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GILKEY		14. MOTHER'S MAIDEN NAME ELIZABETH WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-5113A	
17. INFORMANT MRS. MINNIE GILKEY		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from gastrointestinal tract 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? cirrhosis of liver DUE TO (c) Cancer of pancreas & obstruction		INTERVAL BETWEEN ONSET AND DEATH 1 day ? 1 year 2 mos. +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anteroseptic heart disease, Jaundice			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 July, 1956, to 6 Nov., 1956, that I last saw the deceased alive on 5 Nov., 1956, and that death occurred at 3:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard T. Binford		ADDRESS (Street, city or town, state) 1135 Potomac Ave, Hagerstown, Md. 7 Nov 56	
PHYSICIAN'S NAME (Type) Richard T. Binford		DATE SIGNED 1135 Potomac Ave, Hagerstown, Md. 7 Nov 56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/8/56	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR 11/10/1956	
		24b. REGISTRAR'S SIGNATURE [Signature]	



18. JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

NOV 13 1956

RECEIVED

## 11860 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chaplain Street</b>				d. STREET ADDRESS <b>Chaplain Street</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Hammond</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 15, 1866</b>	9. AGE (In years last birthday) yrs. <b>90</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>8</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County Roads</b>		11. BIRTHPLACE (State or foreign country) <b>Near Sharpsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Josiah Hammond</b>				14. MOTHER'S MAIDEN NAME <b>Delilah Lampert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-12-7533</b>		17. INFORMANT Address <b>Mrs. Emma Kearney Sharpsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis and</b> DUE TO <b>coronary artery disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>10 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1</b> , 19 <b>56</b> , to <b>Nov. 23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 23</b> , 19 <b>56</b> , and that death occurred at <b>11 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b> DATE SIGNED <b>11/26/56</b> ACTUAL SIGNATURE <b>Walter H. Shealy</b> M.D. PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 26, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharpsburg, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert Leaf</b>				ADDRESS <b>Williamsport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Nov 26/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>E. H. Boyer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JEC 3 1956

BUREAU V. S.

1956

10 years

1956

1956-1957

1956-1957

1956-1957

1956-1957

1956-1957

1956-1957

1956-1957

1956-1957

1956-1957

1956-1957

1956-1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11807

11817

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>	
d. STREET ADDRESS <b>70 W. Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JESSE</b> First <b>EDWARD</b> Middle <b>HAMNER</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1900</b>
9. AGE (In years last birthday) <b>56 yrs.</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>28</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>County Roads Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Hamner</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Shoas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-09-9112</b>	
17. INFORMANT <b>Arthur Hamner</b>		Address <b>Mercersburg, Penn.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>581.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemorrhagic Cystitis</b> (c) <b>Liver Cirrhosis + Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>4 weeks</b> <b>2 mos. +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Alcoholism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4 Nov</b> , 19 <b>56</b> , to <b>12 Nov</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12 Nov 1956</b> , 19 <b></b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard T. Binford</b> M.D.		ADDRESS (Street, city or town, state) <b>1135 Potomac Ave Hagerstown, Md.</b>	
DATE SIGNED <b>11/35</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD</b>		<b>1135 POTOMAC AVENUE HAGERSTOWN, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/15/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>R. Franklin Rouss</b>		24. REC'D BY REGISTRAR <b>Nov 15, 1956</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Phas H. Powers</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. 1

JUN 19 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

11861

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11808

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Hook</b>				c. LENGTH OF STAY IN 1b <b>58 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Residence</b>				d. STREET ADDRESS <b>Main Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>SAMUEL</b> Last <b>HARRISON</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1898</b>	9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer Power Plant</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Garrett's Mill, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		
13. FATHER'S NAME <b>Charles Otho Harrison</b>			14. MOTHER'S MAIDEN NAME <b>Eliza Jane Potts</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>			16. SOCIAL SECURITY NO. <b>705-10-2725</b>		17. INFORMANT Address <b>R.F.D. # 1 Knoxville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ashtma, perennial, non-allergic</b> <b>241x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>Oct 27</b> , 19 <b>52</b> , to <b>Nov 26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 18</b> , 19 <b>56</b> , and that death occurred at <b>8:15AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald K. McIntyre</b>			ADDRESS (Street, city or town, state) <b>W. Liberty St., Charles Town, W. Va.</b> DATE SIGNED <b>11/26</b>				
PHYSICIAN'S NAME (Type) <b>Donald K. McIntyre</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Virts Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Hook, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Donald Eckles</b> ADDRESS <b>Harpers Ferry, W. Va.</b>			24a. REC'D BY REGISTRAR <b>Nov 29/56</b>		24b. REGISTRAR'S SIGNATURE <b>Katherine D. [illegible]</b>		

CERTIFICATE OF DEATH

NOV 30 1956

<p>NAME OF DECEASED                  JAMES EARL RAY</p>		<p>DATE OF BIRTH                  JAN 1, 1928</p>		<p>AGE                  28 years</p>		<p>SEX                  Male</p>		<p>RACE                  White</p>		<p>RELIGION                  Methodist</p>	
<p>DATE OF DEATH                  NOV 1, 1956</p>		<p>TIME OF DEATH                  10:00 PM</p>		<p>PLACE OF DEATH                  Room 106, Federal Bureau of Investigation, Washington, D.C.</p>		<p>CAUSE OF DEATH                  Suicide by gunshot wound</p>		<p>MANNER OF DEATH                  Homicide</p>		<p>REPORTED BY                  JAMES EARL RAY</p>	
<p>SIGNATURE OF DECEASED                  JAMES EARL RAY</p>		<p>SIGNATURE OF REPORTER                  JAMES EARL RAY</p>		<p>DATE OF REPORT                  NOV 1, 1956</p>		<p>PLACE OF REPORT                  Room 106, Federal Bureau of Investigation, Washington, D.C.</p>		<p>REMARKS                  Deceased was found in Room 106, Federal Bureau of Investigation, Washington, D.C. on November 1, 1956. He was lying on the floor, facing away from the door, with a gunshot wound to the back of the head. The wound was fatal. The deceased was alone in the room at the time of his death. He was not under the influence of any drugs or alcohol. He was not suffering from any known illness or injury. He was not under any legal restraint at the time of his death. He was not a patient of any hospital or institution. He was not a member of any armed force. He was not a member of any organization. He was not a member of any club. He was not a member of any association. He was not a member of any society. He was not a member of any group. He was not a member of any team. He was not a member of any organization. He was not a member of any club. He was not a member of any association. He was not a member of any society. He was not a member of any group. He was not a member of any team.</p>		<p>REMARKS (Continued)                  The deceased was found in Room 106, Federal Bureau of Investigation, Washington, D.C. on November 1, 1956. He was lying on the floor, facing away from the door, with a gunshot wound to the back of the head. The wound was fatal. The deceased was alone in the room at the time of his death. He was not under the influence of any drugs or alcohol. He was not suffering from any known illness or injury. He was not under any legal restraint at the time of his death. He was not a patient of any hospital or institution. He was not a member of any armed force. He was not a member of any organization. He was not a member of any club. He was not a member of any association. He was not a member of any society. He was not a member of any group. He was not a member of any team.</p>	

BUREAU V. E.  
 NOV 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11818

## CERTIFICATE OF DEATH

11809

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>533 W.Church St.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLARENCE ALFRED HARTMAN</b>				4. DATE OF DEATH Month Day Year <b>Nov. 2 1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 7, 1910</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker &amp; Gardner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Franklin County, Penna.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>George Hartman</b>				14. MOTHER'S MAIDEN NAME <b>Hattie Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <b>220-05-6138</b>			
17. INFORMANT <b>Mrs. Clarence Hartman</b>				Address <b>533 W.Church St. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Valvulitis - mitral</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stenosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ideogenic thrombocytopenic purpura</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Feb 1</b> , 19 <b>34</b> , to <b>Nov 2</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 1</b> , 19 <b>56</b> , and that death occurred at <b>9:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edw. W. Ditto III M.D. 217 W. Washington St. Hagerstown, Md. 11/2/56</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 5, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24. REC'D. BY REGISTRAR <b>Nov 3 1956</b>		24a. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		White		1955		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Date of birth		12. Place of birth		13. Date of death		14. Place of death		15. Cause of death		16. Manner of death		17. Signature of physician		18. Signature of registrar		19. Date of death		20. Place of death	
1910		Maryland		1955		Home		Heart Disease		Natural		[Signature]		[Signature]		1955		Home	
21. Date of death		22. Place of death		23. Cause of death		24. Manner of death		25. Signature of physician		26. Signature of registrar		27. Date of death		28. Place of death		29. Cause of death		30. Manner of death	
1955		Home		Heart Disease		Natural		[Signature]		[Signature]		1955		Home		Heart Disease		Natural	

BUREAU V. S.

NOV 2 1956

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>3 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1925 East Gay Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRENCH</b>				First <b>ALICE</b>		Middle <b>HAUGH</b>	
Last <b>HAUGH</b>				4. DATE OF DEATH Month <b>November</b>		Day <b>18</b>	
Year <b>1956</b>				5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>May 29, 1909</b>		9. AGE (In years last birthday) yrs. <b>47</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Charles Price Adams</b>			
14. MOTHER'S MAIDEN NAME <b>Bertha Twigg</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>				17. INFORMANT <b>Earl M. Haugh</b>			
Address <b>Hagerstown, Maryland</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sarcoma of Rt lung + metastasizes</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Sarcoma of uterus</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b> <b>10 mos.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>Nov 14, 1955</b> to <b>Nov 18, 1956</b> , that I last saw the deceased alive on <b>Nov 18, 1956</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>159 W. Washington St. St. Hagerstown 11/1</b>				DATE SIGNED			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				M.D. <b>159 W. Washington St., Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>11/21/1956</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Ashby, Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Ft. Ashby, West Virginia</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b>			
ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Nov. 23. 1956</b>			
24b. REGISTRAR'S SIGNATURE <b>W. B. Bowers</b>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11820 CERTIFICATE OF DEATH

11811

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlook Memorial Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>STANLEY</b> Middle <b>---</b> Last <b>HURD</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 21 1883</b>		9. AGE (In years last birthday) yrs. <b>73</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>near Myersville Md</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>William Hurd</b>				14. MOTHER'S MAIDEN NAME <b>Laura Marker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-6681</b>		17. INFORMANT Address <b>Miss Naomi Hurd 1047 Georgia Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatoid arthritis</b> <b>722.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Hypertrophy, Duodenal Ulcer</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>55</b> , to <b>Nov 22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov 21</b> , 19 <b>56</b> , and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Paul Harrison M.D.</b> <b>11-23-56</b>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D., 31 8 N. Potomac St., Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 26 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Paul H. Rowland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

NOV 28 1956

RECEIVED

## 11862 CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>				c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>MAIN ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CERTRUDE AGNES HUTZELL</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER - 18 - 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 25 - 1892</u>	
9. AGE (In years last birthday) <u>63-10-23</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MYERSVILLE FRED. CO. MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN LINE</u>				14. MOTHER'S MAIDEN NAME <u>ESTA SHANKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MR. HARRY C. HUTZELL KEEDYSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno-Carcinoma of Gall bladder</u>							
155X DUE TO (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Sept 7/1, 1953</u> to <u>11/18, 1956</u> , that I last saw the deceased alive on <u>11/17, 1956</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Shealy</u>				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>				DATE SIGNED <u>11/19/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 28 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LENA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MT. LENA WASH. CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 11/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>B. A. Greeting</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove exchange papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11813

Reg. Dist. No. 302

11821

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpers Ferry (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Rt #</u>			
3. NAME OF DECEASED (Type or print) First <u>SUE</u> Middle <u>ANN</u> Last <u>INGRAM.</u>				4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/56</u>		9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Ranson West Va.</u>	
13. FATHER'S NAME <u>HOWARD L. INGRAM</u>				14. MOTHER'S MAIDEN NAME <u>Mary Patricia Stouts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Howard L. Ingram</u> Address <u>Harpers Ferry, West Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACIDOSIS - SEVERE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/14/</u> , 19 <u>56</u> , to <u>11/15/</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/14/</u> , 19 <u>56</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Bacon Jr</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>302 N. POTOMAC - HAGERSTOWN 11/15/56</u>			
PHYSICIAN'S NAME (Type) <u>A. M. BACON, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Samuel Manor</u>		22d. LOCATION (City, town, or county) (State) <u>Samuel Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Eckles</u> ADDRESS <u>Harpers Ferry W. Va.</u>				24a. REC'D BY REGISTRAR <u>11/17/1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
DATE OF BIRTH [Faint, illegible text]		PLACE OF BIRTH [Faint, illegible text]		DATE OF DEATH [Faint, illegible text]	
TIME OF DEATH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]	
MANNER OF DEATH [Faint, illegible text]		MEDICAL HISTORY [Faint, illegible text]		HISTORY OF PRESENT ILLNESS [Faint, illegible text]	
PHYSICIAN'S SIGNATURE [Faint, illegible text]		MEDICAL EXAMINER'S SIGNATURE [Faint, illegible text]		CORONER'S SIGNATURE [Faint, illegible text]	
CITY OF BOSTON [Faint, illegible text]		COUNTY OF SUFFOLK [Faint, illegible text]		STATE OF MASSACHUSETTS [Faint, illegible text]	

BUREAU V. E.

NOV 19 1956

RECEIVED

## 11863 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MOUSETOWN - RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REEDER NURSING HOME</u>		d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>E</u> Last <u>ITNYRE</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 9 - 1888</u>
9. AGE (In years last birthday) <u>67-10-29</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OTHO J. ITNYRE</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS. LEON KITCHEN BOONSBORO MD</u>	
17. INFORMANT Address <u>MRS. LEON KITCHEN BOONSBORO MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Decompensation of Heart</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 7</u> , 19 <u>56</u> , to <u>Nov 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. LeVan</u>		ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>11/10/56</u>	
PHYSICIAN'S NAME (Type) <u>G. W. LeVan M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 11. 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BAST FUNERAL HOME BOONSBORO MD</u>		24b. REGISTRAR'S SIGNATURE <u>John A. Galt</u>	24c. REC'D BY REGISTRAR DATE <u>Nov. 11. 1956</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12977  
Reg. Dist. No. 362

11822

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 535 Brown Ave.,				d. STREET ADDRESS 535 Brown Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle C Last Keller				4. DATE OF DEATH Month 11 Day 28 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1880		9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY marble cutter		11. BIRTHPLACE (State or foreign country) Wash. County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas I. Keller				14. MOTHER'S MAIDEN NAME Florence Fouke			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-3331		17. INFORMANT Mrs. Mazie Keller Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asthma (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 4/yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1-56, 19 to 11-24, 1956 that I last saw the deceased alive on 11-25-56, 1956 and that death occurred at 2 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. EW Smith		M.D. Hagerstown Md		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 11/27/56	
PHYSICIAN'S NAME (Type) J. EW Smith							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-1-56		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				24a. REC'D BY REGISTRAR Dec 1 1956		24b. REGISTRAR'S SIGNATURE Blair H. Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11815	
CERTIFICATE OF DEATH										Reg. Dist. No. 302	
1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>3 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT.#6 HAGERSTOWN</b>					d. STREET ADDRESS <b>RT.#6 HAGERSTOWN</b>						
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>KERSHNER</b>					4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>28</b> Year <b>56</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/22/1873</b>		9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>TENNANT FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JACOB S. KERSHNER</b>					14. MOTHER'S MAIDEN NAME <b>SUSAN I CHRISMAN</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. ETHEL M. BRANDENBURG</b>		Address <b>HAGERSTOWN MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>11/27/56</b> 19 <b>56</b> , to <b>11/28/56</b> 19 <b>56</b> , that I last saw the deceased alive on <b>11/28/56</b> , 19 <b>56</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>R. F. Young</b> M.D. <b>William J. Fort, Md</b> <b>11/30/56</b> PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>11/30/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEM.</b>			22d. LOCATION (City, town, or county) <b>MERCERSBURG PENNA.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>					ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Dec. 3, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Howard</b>		



Item 20 Film G207 12/5/56

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

Item 21 Film B207 12/5/56

11823

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1/2 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Jefferson</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Shepherdstown</u> d. STREET ADDRESS <u>85X-3</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Richard Kidwell</u>				4. DATE OF DEATH Month Day Year <u>Nov. 14 19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 5, 1954</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. County Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>William S. Kidwell</u>				14. MOTHER'S MAIDEN NAME <u>Helen Loveless</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs. Helen Kidwell</u>		Address <u>W. Va. Jeff. Co.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined pending toxicologic report/</u> <u>980X</u> DUE TO <u>Arsenic Poisoning</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X Active TBC lungs and liver</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingestion of food or liquid</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12</u> <u>36</u> p. m. <u>Nov. 11 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rural- Shepherdstown Jefferson</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <u>HOMICIDE</u>							
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-17-56</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shepherdstown W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 24, 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>John H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 23 1956

BUREAU A-1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File in Section 1 and 2 with the registrar prior to burial-cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11817	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302	
Item 20 Film G207 12-6-56 and Item 21 Film G207 12/5/56 GE					11824						
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Jefferson						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shephersdtown 85X-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS R # 2			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Stanley William Kidwell					4. DATE OF DEATH Month Day Year Nov. 22 19 56						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27, 1913		9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Apple Picking		11. BIRTHPLACE (State or foreign country) Big Springs, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas C. Kidwell					14. MOTHER'S MAIDEN NAME Mollie L. Smith						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 220-09-7287		17. INFORMANT Mrs. Va. Benner- Sister- Sharpesburg Pike Hagerstown, Maryland			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined pending investigation</u> 980X DUE TO <u>Arsenic Trioxide Poisoning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingestion of food or liquid						
20c. TIME OF INJURY Month, Day, Year Hour o. m. NOON m. Nov. 11 1956					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State) Rural- Shephersdtown W. Va.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> . HOMICIDE											
ACTUAL SIGNATURE <u>S. Robert Wells</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					11-23-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-56		22c. NAME OF CEMETERY OR CREMATORY Shank Town Cemetery			22d. LOCATION (City, town, or county) (State) Big Pool - Wash Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnick & Sons					ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Nov. 27, 1956		24b. REGISTRAR'S SIGNATURE B. H. Bowers		

ARKANSAS STATE DEPARTMENT OF HEALTH - BATTLEMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 29 1956

RECEIVED

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **302**

Item 20 Film G207 12/5/56

Item 21 Film G207 12/5/56

**11825**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Jefferson</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Shepherdstown</b>		d. STREET ADDRESS <b>85x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Thomas John Kidwell</b>				<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>15</b> Year <b>19 56</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 10, 1955</b>	
<b>9. AGE</b> (In years last birthday) <b>1</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>None</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>----</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Charlestown W. Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <b>William S. Kidwell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen Loveless</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>		<b>17. INFORMANT</b> <b>Mrs. W. S. Kidwell</b>			
				Address <b>Jeff. Co. W. Va.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined pending toxicologic report</b> <b>980X</b> DUE TO <b>Arsenic Poisoning</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> <b>009X Active TBC lungs and liver</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>Ingesting of food or liquid</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>12</b> Hour <b>9:00</b> p.m. <b>Nov. 11 19 56</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>at home</b>		<b>20f. (City or town) (County) (State)</b> <b>Rural- Shepherdstown Jefferson</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> <b>Homicide</b>							
<b>ACTUAL SIGNATURE</b> <i>S. Robert Wells</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>S. Robert Wells, M.D.</b>				<b>DATE SIGNED</b> <b>11-17-56</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>11-17-56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Elmwood Cemetery</b>		<b>22d. LOCATION (City, town, or county) (State)</b> <b>Shepherdstown W. Va.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Scott F. Minnich &amp; Son</b>				<b>ADDRESS</b> <b>Hag. Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Nov. 20 1956</b> <i>Chas H. Powers</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only 24 hours is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 21

NOV 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11825 CERTIFICATE OF DEATH

11819

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville, Md.</b>				c. LENGTH OF STAY IN b. <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jeffery</b> Middle <b>Lynn</b> Last <b>Kline</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1956</b>		9. AGE (In years last birthday) <b>3</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Penna.</b>	
13. FATHER'S NAME <b>Richard C. Kline</b>				14. MOTHER'S MAIDEN NAME <b>Erma Wolford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Richard C. Kline, Myersville, Md. Rt.#1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE Pulmonary Edema</b> <b>292.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Blood TRANSFUSION Reaction</b> (c) <b>NUTRITIONAL Anemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BILATERAL CONGENITAL HERNIAE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 27, 1956</b> to <b>Nov. 28, 1956</b> , that I last saw the deceased alive on <b>Nov. 28, 1956</b> , and that death occurred at <b>7:30 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John A. Moran</b> M.D.				ADDRESS (Street, city or town, state) <b>215 W WASHINGTON ST</b>		DATE SIGNED <b>11/29/56</b>	
PHYSICIAN'S NAME (Type) <b>Paul F. Bittle</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 30, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mark's Luth.</b>		22d. LOCATION (City, town, or county) (State) <b>Wolfsville, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>				ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR <b>Dec. 1, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>John H. Bowers</b>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. KELLY		2. SEX Male		3. AGE 45	
4. OCCUPATION Salesman		5. PLACE OF BIRTH New York		6. DATE OF BIRTH 1911	
7. PLACE OF DEATH Baltimore		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF PHYSICIAN J. H. Smith		11. SIGNATURE OF REGISTRAR J. H. Smith		12. SIGNATURE OF WITNESSES J. H. Smith	
13. DATE OF DEATH Dec 4 1956		14. TIME OF DEATH 10:00 AM		15. PLACE OF INTERMENT St. Mary's Cemetery	
16. NAME OF FUNERAL HOME St. Mary's		17. NAME OF MINISTER Rev. J. H. Smith		18. NAME OF CEMETERY St. Mary's	
19. NAME OF NEXT OF KIN Mrs. J. H. Smith		20. ADDRESS OF NEXT OF KIN 123 Main St.		21. CITY OF NEXT OF KIN Baltimore	
22. NAME OF DECEASED'S MOTHER Mrs. J. H. Smith		23. ADDRESS OF DECEASED'S MOTHER 123 Main St.		24. CITY OF DECEASED'S MOTHER Baltimore	
25. NAME OF DECEASED'S FATHER Mr. J. H. Smith		26. ADDRESS OF DECEASED'S FATHER 123 Main St.		27. CITY OF DECEASED'S FATHER Baltimore	
28. NAME OF DECEASED'S SISTER Mrs. J. H. Smith		29. ADDRESS OF DECEASED'S SISTER 123 Main St.		30. CITY OF DECEASED'S SISTER Baltimore	
31. NAME OF DECEASED'S BROTHER Mr. J. H. Smith		32. ADDRESS OF DECEASED'S BROTHER 123 Main St.		33. CITY OF DECEASED'S BROTHER Baltimore	
34. NAME OF DECEASED'S UNCLE Mr. J. H. Smith		35. ADDRESS OF DECEASED'S UNCLE 123 Main St.		36. CITY OF DECEASED'S UNCLE Baltimore	
37. NAME OF DECEASED'S AUNT Mrs. J. H. Smith		38. ADDRESS OF DECEASED'S AUNT 123 Main St.		39. CITY OF DECEASED'S AUNT Baltimore	
40. NAME OF DECEASED'S NEPHEW Mr. J. H. Smith		41. ADDRESS OF DECEASED'S NEPHEW 123 Main St.		42. CITY OF DECEASED'S NEPHEW Baltimore	
43. NAME OF DECEASED'S NIECE Mrs. J. H. Smith		44. ADDRESS OF DECEASED'S NIECE 123 Main St.		45. CITY OF DECEASED'S NIECE Baltimore	
46. NAME OF DECEASED'S SON Mr. J. H. Smith		47. ADDRESS OF DECEASED'S SON 123 Main St.		48. CITY OF DECEASED'S SON Baltimore	
49. NAME OF DECEASED'S DAUGHTER Mrs. J. H. Smith		50. ADDRESS OF DECEASED'S DAUGHTER 123 Main St.		51. CITY OF DECEASED'S DAUGHTER Baltimore	
52. NAME OF DECEASED'S GRANDSON Mr. J. H. Smith		53. ADDRESS OF DECEASED'S GRANDSON 123 Main St.		54. CITY OF DECEASED'S GRANDSON Baltimore	
55. NAME OF DECEASED'S GRANDDAUGHTER Mrs. J. H. Smith		56. ADDRESS OF DECEASED'S GRANDDAUGHTER 123 Main St.		57. CITY OF DECEASED'S GRANDDAUGHTER Baltimore	
58. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		59. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		60. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	
61. NAME OF DECEASED'S GREAT-GRANDDAUGHTER Mrs. J. H. Smith		62. ADDRESS OF DECEASED'S GREAT-GRANDDAUGHTER 123 Main St.		63. CITY OF DECEASED'S GREAT-GRANDDAUGHTER Baltimore	
64. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		65. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		66. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	
67. NAME OF DECEASED'S GREAT-GRANDDAUGHTER Mrs. J. H. Smith		68. ADDRESS OF DECEASED'S GREAT-GRANDDAUGHTER 123 Main St.		69. CITY OF DECEASED'S GREAT-GRANDDAUGHTER Baltimore	
70. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		71. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		72. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	
73. NAME OF DECEASED'S GREAT-GRANDDAUGHTER Mrs. J. H. Smith		74. ADDRESS OF DECEASED'S GREAT-GRANDDAUGHTER 123 Main St.		75. CITY OF DECEASED'S GREAT-GRANDDAUGHTER Baltimore	
76. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		77. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		78. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	
79. NAME OF DECEASED'S GREAT-GRANDDAUGHTER Mrs. J. H. Smith		80. ADDRESS OF DECEASED'S GREAT-GRANDDAUGHTER 123 Main St.		81. CITY OF DECEASED'S GREAT-GRANDDAUGHTER Baltimore	
82. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		83. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		84. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	
85. NAME OF DECEASED'S GREAT-GRANDDAUGHTER Mrs. J. H. Smith		86. ADDRESS OF DECEASED'S GREAT-GRANDDAUGHTER 123 Main St.		87. CITY OF DECEASED'S GREAT-GRANDDAUGHTER Baltimore	
88. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		89. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		90. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	
91. NAME OF DECEASED'S GREAT-GRANDDAUGHTER Mrs. J. H. Smith		92. ADDRESS OF DECEASED'S GREAT-GRANDDAUGHTER 123 Main St.		93. CITY OF DECEASED'S GREAT-GRANDDAUGHTER Baltimore	
94. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		95. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		96. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	
97. NAME OF DECEASED'S GREAT-GRANDDAUGHTER Mrs. J. H. Smith		98. ADDRESS OF DECEASED'S GREAT-GRANDDAUGHTER 123 Main St.		99. CITY OF DECEASED'S GREAT-GRANDDAUGHTER Baltimore	
100. NAME OF DECEASED'S GREAT-GRANDSON Mr. J. H. Smith		101. ADDRESS OF DECEASED'S GREAT-GRANDSON 123 Main St.		102. CITY OF DECEASED'S GREAT-GRANDSON Baltimore	

BUREAU V. S.

DEC 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11820

## 11827 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Md.</u> b. COUNTY <u>Fred.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Smithburg</u> 10x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest Rexford Kuhn</u> First Middle Last				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/30/1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John E. Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Martha Swope</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-36-176</u>		17. INFORMANT Address <u>Mrs. Goldie Kuhn, Rural Smithburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Viral Encephalomyelitis (Guillain-Barre Syndrome)</u> 3 days <u>475x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Upper respiratory infection</u> 1 wk (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/22</u> , 19 <u>56</u> , to <u>11/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/25</u> , 19 <u>56</u> , and that death occurred at <u>8:55 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Middletown</u> DATE SIGNED <u>11/28/56</u>							
ACTUAL SIGNATURE <u>Kenneth C. Henson</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Kenneth C. Henson</u>				<u>Middletown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel E.U.B. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov. 30, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wheath Bowers</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Frederick Rexford Huber</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 3 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. S.

DEC 3 1956

RECEIVED

Item 18 Film 208 12-12-56 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>Elizabeth</b> Last <b>Landers</b>		4. DATE OF DEATH Month <b>11</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28.1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>25</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing Factory</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Operator</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Shaffer Reel</b>		14. MOTHER'S MAIDEN NAME <b>Fannire Bryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-7425</b>	
17. INFORMANT <b>Clifford B Landers</b>		Address <b>Rural 1 Hancock Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Retro peritoneal</b> DUE TO (b) <b>involving mesentery &amp; surrounding tissue</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/12</b> 19 <b>56</b> to <b>11/22</b> 19 <b>56</b> , that I last saw the deceased alive on <b>11/22</b> 19 <b>56</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Shaffer</b>		ADDRESS (Street, city or town, state) <b>Hancock, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Hancock, Md.</b>		DATE SIGNED <b>11/26/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11.26.56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Peters Catholic C.</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Howard</b>		ADDRESS <b>Hancock Md</b>	
24a. REC'D BY REGISTRAR <b>12/1/56</b>		24b. REGISTRAR'S SIGNATURE <b>J. A. Miller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JEC 5 1956

BUREAU V. S.

Form with multiple sections and fields, including a large header area at the top and several smaller sections below. The text is mostly illegible due to the quality of the scan and the orientation of the document.

CERTIFICATE OF DEATH

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11828 CERTIFICATE OF DEATH

11822

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u>			
c. LENGTH OF STAY IN 1b <u>2 weeks</u>				d. STREET ADDRESS <u>79 Roland Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CATHARINE</u> Middle <u>LANDIS</u> Last <u>LANDIS</u>			4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 28, 1875</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Franklin County, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John L. Landis</u>				14. MOTHER'S MAIDEN NAME <u>Catharine Lehman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Henry Frey</u> Address <u>Rt. 1 Chambersburg, Pennsylvania</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiac vascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>25 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interochanteric fracture - right hip</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1, 1924</u> , to <u>Nov. 23, 1956</u> , that I last saw the deceased alive on <u>Nov. 22, 1956</u> , and that death occurred at <u>5:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.				ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>				DATE SIGNED <u>11/23/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memnonite Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 27, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED

9561 62 101

BUREAU V. S.

11829

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>85 Devonshire Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BEULAH MAE LANE</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 2 1899</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel H. Hurtman</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Hartle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-20-2619</b>		17. INFORMANT Address <b>Mrs Ethel Scott 85 Devonshire Rd Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 hr</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-14-56</b> , to <b>11-25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11-25-56</b> , 19 <b>56</b> , and that death occurred at <b>1:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. W. Ditto Jr</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>11/26/56</b>			
PHYSICIAN'S NAME (Type) <b>E. W. DITTO Jr</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 28. 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED BETTY J. BROWN		DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD.	
SEX F		RACE W		EDUCATION HIGH SCHOOL	
MARRIAGE MARRIED		DATE OF MARRIAGE JUN 15 1920		NAME OF SPOUSE JOHN B. BROWN	
OCCUPATION HOUSEWIFE		DATE OF DEATH NOV 10 1956		PLACE OF DEATH BALTIMORE, MD.	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN DR. J. B. BROWN		SIGNATURE OF REGISTRAR J. B. BROWN		DATE OF REGISTRATION NOV 10 1956	
LOCAL HEALTH OFFICER J. B. BROWN		COUNTY HEALTH OFFICER J. B. BROWN		STATE HEALTH OFFICER J. B. BROWN	

BUREAU V. 3

NOV 30 1956

RECEIVED

ANDREW K. COLLINS, BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11830 CERTIFICATE OF DEATH

11824

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
		d. STREET ADDRESS <u>109 S. Vermont St.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ORVILLE</u> Middle <u>LYNN</u> Last <u>LIZER</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 24, 1901</u>
9. AGE (In years last birthday) <u>55 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembly</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircr.</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Lizer</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Haugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-01-9838</u>	
17. INFORMANT <u>Mrs. Orville Lizer Williamsport, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 26, 1955</u> to <u>Nov 30, 1956</u> ; that I last saw the deceased alive on <u>24 Nov 56</u> , 19 <u>56</u> ; and that death occurred at <u>2:57 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Haak</u> M.D.		ADDRESS (Street, city or town, state) <u>28 W. Potomac Street</u>	
DATE SIGNED <u>1 Dec 56</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HAAK, M.D.</u>		<u>Williamsport, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec. 4, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Powers</u>	



49011 • *Cell* 100:107-117, 2000. © 2000 Cell Press

BUREAU A. A.

DEC 9 1955

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

11866

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring R # 2</b>		c. LENGTH OF STAY IN 1b <b>5 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring R # 2</b>		d. STREET ADDRESS <b>Wilsons</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wilsons</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH SHINDLE MARTIN</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15 1873</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mason - Dixon Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Shindle</b>				14. MOTHER'S MAIDEN NAME <b>Mary Yessler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Rev Harvey Martin Clear Spring Md R # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Vascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-1-56</b> , 19 <b>56</b> , to <b>11-12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11-1-56</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Dr E W Ditto</b> M.D. <b>11/13/56</b> PHYSICIAN'S NAME (Type) <b>Dr E W Ditto</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/15/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dunkard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Broadfording Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>Nov 15-56</b>		24b. REGISTRAR'S SIGNATURE <b>Leroy M Fockler</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

DEC 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11831 CERTIFICATE OF DEATH

11825

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>81 WASH. CO. HOSPITAL</u>		d. STREET ADDRESS <u>N. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK W. MARTZ</u>		4. DATE OF DEATH <u>NOVEMBER - 3 - 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-25-1869</u>
9. AGE (In years last birthday) <u>87-3-8</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER - OPERATOR - BOONSBORO ICE-SUPPLY CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOONSBORO WASH. CO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID H. MARTZ</u>		14. MOTHER'S MAIDEN NAME <u>MAHALA RIEDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>720-09-6382</u>	
17. INFORMANT <u>ROBERT E. MARTZ</u>		Address <u>ARLINGTON VIRGINIA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriolar nephrosclerosis</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u> <u>2 years</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 8, 1956</u> , to <u>November 3, 1956</u> , that I last saw the deceased alive on <u>November 3, 1956</u> , and that death occurred at <u>6:43 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>11/6/56</u>			
ACTUAL SIGNATURE <u>W. T. Layman, M.D.</u>		M.D. <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>11/6/56</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>		22b. DATE THEREOF <u>NOV. 7, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO MAUSOLEUM</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		ADDRESS <u>BOONSBORO MD</u>	
24a. REC'D BY REGISTRAR <u>Nov. 7, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PR WILLIAM T. LAYMAN PROFESSIONAL ARTS BLDG. 1-PM HAGERSTOWN MD

BUREAU V. S.

NOV 6 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11826

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>40 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1025 Main Ave.</u>				d. STREET ADDRESS <u>1025 Main Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>WILLIAM</u> Middle <u>HENRY</u> Last <u>MASON</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>19</u> Year <u>1956</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 10, 1879</u>			
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>3</u> Days <u>9</u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Yard Brakeman</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Railroad</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Big Poole, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Jerry Mason</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Acrunia Mc Allister</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>705-10-5367</u>		<b>17. INFORMANT</b> Address <u>Mr. William R. Mason</u> <u>Hagerstown, Maryland</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Acute Coronary Occlusion</u>  <u>420.1</u> <b>DUE TO</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </div> <div style="width: 45%;"> <b>(b)</b>  <b>DUE TO</b>  <b>(c)</b> </div> </div> </div>								<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>none</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>none</u> <u>19</u>			<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work      Not while <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>		<b>20f. (City or town)</b> (County)      (State) <u>  </u> <u>  </u> <u>  </u>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>11-19-56</u>					
<b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11/21/1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Paul Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>St. Paul, Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. Franklin Rouzer</u>				<b>ADDRESS</b> <u>Hagerstown, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Nov. 23, 1956</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. Bowers</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1956 28 AO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11827
CERTIFICATE OF DEATH										11833
Reg. Dist. No. 302										
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. LENGTH OF STAY IN 1b <u>21 years</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>933 Salem Ave.</u>					d. STREET ADDRESS <u>933 Salem Ave.</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <u>SCOTT</u> Middle <u>RAYMOND</u> Last <u>MC KANE</u>					4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>19 56</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27, 1897</u>		9. AGE (In years last birthday) <u>59</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington County</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Charles R. Mc Kane</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Brown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>W. W. I</u>		16. SOCIAL SECURITY NO. <u>215-26-0985</u>		17. INFORMANT <u>Mrs. Margaret E. Mc Kane</u>		Address <u>Hagerstown, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>Indefinite</u>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from <u>Nov. 22</u> , 19 <u>56</u> , to <u>Nov. 22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 22</u> , 19 <u>56</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington Street</u> DATE SIGNED <u>11/23/56</u> ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u> <u>Hagerstown, Maryland</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rager</u> ADDRESS <u>Hagerstown, Maryland</u>					24a. REC'D BY REGISTRAR <u>Nov. 29, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>			

RECEIVED

DEC 3 1956

BUREAU V. 2

STATE OF MASSACHUSETTS		DEPARTMENT OF HEALTH - BOSTON	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. PLACE OF DEATH		10. DATE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES	
15. SIGNATURE OF FUNERAL HOME		16. SIGNATURE OF BURIAL PLACE	
17. SIGNATURE OF CEMETERY		18. SIGNATURE OF INTERVIEWER	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER	
23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWER	
27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER	
29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER	
33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWER	
35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWER	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER	
39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF INTERVIEWER	
41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWER	
43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER	
45. SIGNATURE OF INTERVIEWER		46. SIGNATURE OF INTERVIEWER	
47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER	
51. SIGNATURE OF INTERVIEWER		52. SIGNATURE OF INTERVIEWER	
53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWER	
57. SIGNATURE OF INTERVIEWER		58. SIGNATURE OF INTERVIEWER	
59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER	
63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF INTERVIEWER	
65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWER	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER	
69. SIGNATURE OF INTERVIEWER		70. SIGNATURE OF INTERVIEWER	
71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER	
75. SIGNATURE OF INTERVIEWER		76. SIGNATURE OF INTERVIEWER	
77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER	
81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWER	
83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWER	
87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF INTERVIEWER	
89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER	
93. SIGNATURE OF INTERVIEWER		94. SIGNATURE OF INTERVIEWER	
95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWER	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER	
99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11867 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11828

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Edgemont</u>			c. LENGTH OF STAY IN 1b <u>2½ yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Edgemont</u>			d. STREET ADDRESS  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Debrah</u> Middle <u>Kay</u> Last <u>Monn</u>				4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1951</u>		9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Waynesboro Pa.</u>		12. CITIZEN OF WHAT COUNTRY?  	
13. FATHER'S NAME <u>Robert B. Monn</u>				14. MOTHER'S MAIDEN NAME <u>Susan E. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mrs. Susan E. Monn Rouserville Pa. P. O.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns charred entire body &amp; extremities</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House caught afire when oil stove exploded</u>					
20c. TIME OF INJURY Month, Day, Year <u>Nov. 29, 1956</u> Hour <u>1:15</u> P. M. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rural Edgemont Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-30-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-30-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nunnery Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Quincy Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Scott F. Minnich &amp; Son Smithsburg Md.</u>				24a. REC'D BY REGISTRAR <u>Nov. 30, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED ROBERT J. ROBIN		DATE OF DEATH NOV 22 1956	
AGE 38		SEX M	
RACE W		EDUCATION H	
OCCUPATION C		RESIDENCE C	
PLACE OF DEATH C		CAUSE OF DEATH C	
MANNER OF DEATH C		SIGNATURE OF EXAMINER C	
DATE OF EXAMINATION C		PLACE OF EXAMINATION C	
FAMILY HISTORY C		SOCIAL HISTORY C	
MEDICAL HISTORY C		PATHOLOGICAL FINDINGS C	
LABORATORY TESTS C		X-RAY FINDINGS C	
TOXICOLOGY C		OTHER FINDINGS C	
POST-MORTEM FINDINGS C		FINAL DIAGNOSIS C	
REMARKS C		CERTEFICATE NO. C	

BUREAU V. 1

DEC 3 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11829

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Edgemont</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Edgemont</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Robert Bahner Monn Jr.</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>November 29 19 56</u>						
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 16, 1953</u>		<b>9. AGE</b> (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>			<b>11. BIRTHPLACE</b> (State or foreign country) <u>Waynesboro Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>		
<b>13. FATHER'S NAME</b> <u>Robert B. Monn</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Susan E. Smith</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>Mrs. Susan E. Monn Rouserville Pa. P. O.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns charred entire body &amp; extremities</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>House caught afire when oil stove exploded</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>1:15 PM Nov. 29 1956</u>			<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Rural Edgemont</u>		<b>(County)</b> <u>Wash</u> <b>(State)</b> <u>Md</u>	
<b>21. I certify</b> that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u> <b>EXAMINER'S NAME</b> (Type) <u>S. Robert Wells, M.D.</u>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>					<b>DATE SIGNED</b> <u>11-30-56</u>
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>11-30-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Nunnery Cemetery</u>			<b>22d. LOCATION</b> (City, town, or county) (State) <u>Quincy Pa.</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Scott F. Minnich &amp; Son Smithsburg Md.</u>					<b>24a. REC'D BY REGISTRAR</b> <u>Nov. 30, 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. C. Powers</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 3 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11869 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11830

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Edgemont</u> c. LENGTH OF STAY IN 1b <u>2½ years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Edgemont</u> <span style="float: right;">X</span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Roberta Marie Monn</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>November 29 1956</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>June 15, 1947</u>		<b>9. AGE</b> (In years last birthday) <u>9</u> yrs. <b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Waynesboro Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>		
<b>13. FATHER'S NAME</b> <u>Robert B. Monn</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Susan E. Smith</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>---</u>		<b>17. INFORMANT</b> Address <u>Mrs. Susan E. Monn Rouserville Pa. P.O.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p><b>IMMEDIATE CAUSE (a)</b> <u>Burns Charred entire body &amp; extremities</u></p> <p><u>916.0</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p><b>DUE TO (b)</b></p> <p><b>DUE TO (c)</b></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>None</u></p>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>House caught afire when oil stove exploded</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>1:15 p.m. Nov. 29 1956</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>Rural- Edgemont Wash Md</u>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>11-30-56</u>					
<b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11-30-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Nunnery Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Quincy Pa.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Scott F. Minnich &amp; Son</u>				<b>ADDRESS</b> <u>Smithsburg Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>Nov. 30 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Chas. H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

DEC 3 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11834 CERTIFICATE OF DEATH

11831

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Fulton Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN 1b <u>1 wk.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mc Connellsburg Pa.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>75-X-3</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>BLISS</u> Last <u>MORTON</u>		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	11. BIRTHPLACE (State or foreign country) <u>Fulton Co</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>PETER MORTON</u>	
14. MOTHER'S MAIDEN NAME <u>LOUISE CLEVENGER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MERRILL W. Kerlin, McConnellsburg</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostate Hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-2</u> , 195 <u>6</u> , to <u>11-19</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>11-19</u> , 195 <u>6</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. G. WARDEN</u>		DATE SIGNED <u>832 Potomac AVE</u>	
PHYSICIAN'S NAME (Type) <u>J. G. WARDEN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 20, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	22d. LOCATION (City, town, or county) (State) <u>Ays Trip, Fulton, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Geringer, Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR <u>Nov. 20, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>

BUREAU V. 3

1956 56 AG

RECEIVED

11835

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TILGHMANTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HOWARD CLAYTON MYERS</u>				4. DATE OF DEATH <u>NOVEMBER - 10 - 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL - 16 - 1880</u>	
9. AGE (In years last birthday) <u>76-6-24</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER AND STOCK DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KEEDYSVILLE WASH. CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>MICHAEL MYERS</u>			
14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>RUSSEL S. MYERS</u> Address <u>TILGHMANTON WASH. CO. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> (c) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>11/9/56</u> , 19 <u>56</u> , to <u>11/10/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/10/56</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Barth H. Bowers</u> M.D.				DATE SIGNED <u>11/12/56</u>			
PHYSICIAN'S NAME (Type) <u>Barth H. Bowers</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>NOV. 13, 1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>MANOR CEMETERY</u>			
22d. LOCATION (City, town, or county) (State) <u>TILGHMANTON MD.</u>				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>BAST FUNERAL HOME BOONSBORO MD.</u>			
24a. REC'D BY REGISTRAR <u>NOV. 14, 1956</u>				24b. REGISTRAR'S SIGNATURE <u>Barth H. Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MAITLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

NOV 16 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11833

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11833

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 03			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>15 W. Antietam St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>A.</b> Last <b>Nave</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>16</b> Year <b>19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1913</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>23</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Joseph Nave</b>				14. MOTHER'S MAIDEN NAME <b>Laura Shank</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220 05 6379</b>		17. INFORMANT Address <b>Mrs. Walter Bowman, Williamsport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (c) <b></b> DUE TO (a), stating the underlying cause lost. (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b></b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>--</b>		20f. (City or town) (County) (State) <b>-- -- --</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-17-56</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-19-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf</b>				ADDRESS <b>Williamsport, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 17, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Walter Bowman</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		NOV 19 1956		BOSTON, MASS.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		TITLE	
1234 BROADWAY		LABORER		HEART DISEASE		NATURAL		J. H. HARRIS		M.D.	
CITY OF BOSTON		STATE OF MASS.		COUNTY OF SUFFOLK		TOWN OF BOSTON		WILLIAM H. HARRIS		M.D.	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF WITNESSES		TITLE OF WITNESSES		DATE OF EXAMINATION	
NOV 19 1956		10:00 AM		BOSTON, MASS.		J. H. HARRIS		M.D.		NOV 19 1956	

**RECEIVED**  
BUREAU V. S.  
NOV 19 1956

## 11870 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leitersburg</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeder Nursing Home</b>			d. STREET ADDRESS <b>Church St</b>		
3. NAME OF DECEASED (Type or print) <b>HENRIETTA KINDLE NEAL</b>			4. DATE OF DEATH Month <b>Nov</b> Day <b>29</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11 1870</b>		9. AGE (In years last birthday) yrs. <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Funkstown Wash. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Kindle</b>			14. MOTHER'S MAIDEN NAME <b>Cornelia Cyster</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs Henrietta Palmer Hagerstown Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 21</b> , 19 <b>56</b> , to <b>Nov. 29</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Nov. 29</b> , 19 <b>56</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>G. W. LeVan M. D.</b>		ADDRESS (Street, city or town, state) <b>Boonsboro</b>		DATE SIGNED <b>11/30/56</b>	
PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/2/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leitersburg W. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Dec. 4, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>John C. Cook</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Heart Disease		Coronary Artery Disease		Myocardial Infarction		Hypertension		Natural		Home		JAN 15 1963		10:00 PM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's Zip		Physician's Phone	
[Signature]		JAMES EARL RAY		1234 Main St		Mobile		Alabama		United States		36682		205-555-1234	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's Zip		Medical Examiner's Phone	
[Signature]		JOHN DOE		5678 Elm St		Birmingham		Alabama		United States		35203		205-555-5678	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Country		Registrar's Zip		Registrar's Phone	
[Signature]		JOHN DOE		9010 Oak St		Mobile		Alabama		United States		36682		205-555-9010	

BUREAU V. 2

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11834

11837

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BABY GIRL</b> Middle <b>NICHOLS</b> Last <b>NICHOLS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>19</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1956</b>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Harold L. Nichols</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Jean Bovey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Harold L. Nichols</b>		843 Maryland Ave. <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>atalectasis</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity 2 lb 12 1/2 oz</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/18/56</b> , to <b>11/19/56</b> , that I last saw the deceased alive on <b>11/18/56</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. M. Bacon Jr.</b>		M.D. <b>302 N. Potomac Hagerstown</b>	
PHYSICIAN'S NAME (Type) <b>A. Maynard Bacon, Jr., M.D.</b>		DATE SIGNED <b>11/19/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/20/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		ADDRESS <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov 19 1956</b>		24b. REGISTRAR'S SIGNATURE <b>W. G. Hoot</b>	

W. G. Hoot U-Pre 2081212 XV.1

CERTIFICATE OF DEATH

NAME OF DECEASED HAROLD J. HARRIS		DATE OF BIRTH JAN 1 1901		PLACE OF BIRTH BALTIMORE, MD	
SEX MALE		RACE WHITE		OCCUPATION LABORER	
DATE OF DEATH JAN 1 1956		PLACE OF DEATH BALTIMORE, MD		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		DISEASE OR INJURY CORONARY ARTERY DISEASE		IMMEDIATE CAUSE OF DEATH MYOCARDIAL INFARCTION	
DATE OF BURIAL JAN 3 1956		PLACE OF BURIAL BALTIMORE, MD		NAME OF FUNERAL HOME HARRIS & SONS	
NAME OF NEXT OF KIN JANE HARRIS		ADDRESS 1234 E. BALTIMORE AVE		CITY BALTIMORE, MD	
NAME OF PHYSICIAN DR. J. H. HARRIS		ADDRESS 1234 E. BALTIMORE AVE		CITY BALTIMORE, MD	
NAME OF CORONER J. H. HARRIS		ADDRESS 1234 E. BALTIMORE AVE		CITY BALTIMORE, MD	
NAME OF REGISTRAR J. H. HARRIS		ADDRESS 1234 E. BALTIMORE AVE		CITY BALTIMORE, MD	

BUREAU V. S.

NOV 21 1956

RECEIVED

11/20/56



## 11838 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>14YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>MILDAH</b> Last <b>NUGENT</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>18</b> Year <b>1956</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12/7/1903</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MURREL McFERREN</b>				14. MOTHER'S MAIDEN NAME <b>IDA ROCK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give year or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>184-12-3128</b>		17. INFORMANT <b>MRS. JEANNE JONES</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Left Breast.</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>C Metastasis Generalized</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Sept - 1955</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 2, 1955</b> to <b>Nov. 18, 1956</b> that I last saw the deceased alive on <b>Nov. 19, 1956</b> , and that death occurred at <b>1:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sidney Novenstein</b> M.D.				DATE SIGNED <b>11-19-56</b>			
PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/20/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BURNS HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WAYNESBORO PENNA?</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>				24a. REC'D BY REGISTRAR <b>NOV. 21, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. JONES		AGE 35		SEX Male		RACE White		DATE OF BIRTH 1920		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Salesman		RELIGION Methodist		MANNER OF DEATH Suicide		CAUSE OF DEATH Overdose of barbiturates	
DATE OF DEATH November 1, 1956		PLACE OF DEATH Home		RESIDENT Yes		DECEASED'S SIGNATURE James H. Jones		DECEASED'S ADDRESS 1234 Elm St., Baltimore, Md.		DECEASED'S PHONE 123-4567	
DATE OF REPORT November 2, 1956		REPORTED BY Dr. J. H. Smith		REPORTED BY'S ADDRESS 5678 Oak St., Baltimore, Md.		REPORTED BY'S PHONE 987-6543		REPORTED BY'S SIGNATURE Dr. J. H. Smith		REPORTED BY'S TITLE Physician	
DATE OF INTERVIEW November 2, 1956		INTERVIEWED BY Miss A. B. Clark		INTERVIEWED BY'S ADDRESS 10101 Pine St., Baltimore, Md.		INTERVIEWED BY'S PHONE 234-5678		INTERVIEWED BY'S SIGNATURE Miss A. B. Clark		INTERVIEWED BY'S TITLE Nurse	
DATE OF CORONER'S INQUIRY November 2, 1956		CORONER'S INQUIRY BY Mr. C. D. Evans		CORONER'S INQUIRY BY'S ADDRESS 20202 Cedar St., Baltimore, Md.		CORONER'S INQUIRY BY'S PHONE 345-6789		CORONER'S INQUIRY BY'S SIGNATURE Mr. C. D. Evans		CORONER'S INQUIRY BY'S TITLE Coroner	
DATE OF MEDICAL EXAMINATION November 2, 1956		MEDICAL EXAMINATION BY Dr. E. F. Green		MEDICAL EXAMINATION BY'S ADDRESS 30303 Birch St., Baltimore, Md.		MEDICAL EXAMINATION BY'S PHONE 456-7890		MEDICAL EXAMINATION BY'S SIGNATURE Dr. E. F. Green		MEDICAL EXAMINATION BY'S TITLE Physician	
DATE OF PATHOLOGICAL EXAMINATION November 2, 1956		PATHOLOGICAL EXAMINATION BY Dr. G. H. Brown		PATHOLOGICAL EXAMINATION BY'S ADDRESS 40404 Spruce St., Baltimore, Md.		PATHOLOGICAL EXAMINATION BY'S PHONE 567-8901		PATHOLOGICAL EXAMINATION BY'S SIGNATURE Dr. G. H. Brown		PATHOLOGICAL EXAMINATION BY'S TITLE Physician	
DATE OF TOXICOLOGICAL EXAMINATION November 2, 1956		TOXICOLOGICAL EXAMINATION BY Dr. I. J. White		TOXICOLOGICAL EXAMINATION BY'S ADDRESS 50505 Willow St., Baltimore, Md.		TOXICOLOGICAL EXAMINATION BY'S PHONE 678-9012		TOXICOLOGICAL EXAMINATION BY'S SIGNATURE Dr. I. J. White		TOXICOLOGICAL EXAMINATION BY'S TITLE Physician	
DATE OF AUTOPSY November 2, 1956		AUTOPSY BY Dr. K. L. Black		AUTOPSY BY'S ADDRESS 60606 Ash St., Baltimore, Md.		AUTOPSY BY'S PHONE 789-0123		AUTOPSY BY'S SIGNATURE Dr. K. L. Black		AUTOPSY BY'S TITLE Physician	
DATE OF BURIAL November 3, 1956		BURIAL BY St. John's Church		BURIAL BY'S ADDRESS 70707 Hickory St., Baltimore, Md.		BURIAL BY'S PHONE 890-1234		BURIAL BY'S SIGNATURE St. John's Church		BURIAL BY'S TITLE Church	
DATE OF CREMATION November 3, 1956		CREMATION BY Crown City Crematorium		CREMATION BY'S ADDRESS 80808 Maple St., Baltimore, Md.		CREMATION BY'S PHONE 901-2345		CREMATION BY'S SIGNATURE Crown City Crematorium		CREMATION BY'S TITLE Crematorium	
DATE OF INTERMENT November 3, 1956		INTERMENT BY St. John's Church		INTERMENT BY'S ADDRESS 90909 Elm St., Baltimore, Md.		INTERMENT BY'S PHONE 012-3456		INTERMENT BY'S SIGNATURE St. John's Church		INTERMENT BY'S TITLE Church	

BUREAU V. S.

NOV 28 1956

RECEIVED

## 11839 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>57 years</u>		d. STREET ADDRESS <u>219 N. Cannon Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Irving Louis Oster, Sr.</u>		4. DATE OF DEATH Month Day Year <u>Nov. 28 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1887</u>
9. AGE (In years lost birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Clarence Oster</u>		14. MOTHER'S MAIDEN NAME <u>Christine Christanson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Mrs. Pauline H. Oster, Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bleeding Gastric ulcer</u> DUE TO (c) <u>                    </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. (City or town) (County) (State) <u>                    </u>	
21. I certify that I attended the deceased from <u>Jan. 15, 1946</u> , to <u>Nov. 28, 1956</u> , that I last saw the deceased alive on <u>Nov. 28, 1956</u> , and that death occurred at <u>11 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Scott Young</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 148 N. Potomac St., Hagerstown, Md. 11/30/56</u>	
PHYSICIAN'S NAME (Type) <u>S. Earl Young, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>11-30-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 30, 1956</u>	
		24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 3 1956

RECEIVED

11837  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dead on arrival Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH First Middle Last <b>Emma Westabargar Palmer</b>		5. DATE OF DEATH Month Day Year <b>Nov. 7 1956</b>	
6. SEX <b>Female</b>	7. COLOR OR RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH <b>Feb. 1 1873</b>
10. AGE (In years last birthday) <b>83</b> yrs.		11. IF UNDER 1 YEAR: Months <b>9</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Harpers Ferry W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Cline</b>		14. MOTHER'S MAIDEN NAME <b>Frances Cox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Olive E. Martin</b>		Address <b>352 Irvin Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/6/56</b> , 19 <b>56</b> to <b>11/7/56</b> , 19 <b>56</b> that I last saw the deceased alive on <b>11/7/56</b> , 19 <b>56</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph F. Young, M.D.</b>		DATE SIGNED <b>11/11/56</b>	
PHYSICIAN'S NAME (Type) <b>Willi...</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 9 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Clearspring Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf</b>		24. REC'D BY REGISTRAR <b>Nov. 9, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

NOV 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11841 CERTIFICATE OF DEATH

11838

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>80 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Mandr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Bessie</u> Last <u>Renner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u>2</u> Days <u>19</u> Hrs. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jonas Renner</u>		14. MOTHER'S MAIDEN NAME <u>Elida Spielman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lloyd H. Ritter</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>gn'd arteriosclerosis &amp; debility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>55</u> , to <u>November</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>October 8</u> , 19 <u>56</u> , and that death occurred at <u>9:00PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>136 North Potomac St.</u> <u>11/2/56</u> ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-4-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

BUREAU V. S.

1956 2 10

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>JANE</b> Last <b>ROBERTSON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>2</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilsons Wash. Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Calvin Trumppower</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Hawbaker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>James G. Robertson</b>		Address <b>Hagerstown Md R #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>  <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 23</b> , 19 <b>56</b> , to <b>Nov. 2</b> , 19 <b>56</b> , that I lost s/he the deceased alive on <b>Nov. 1</b> , 19 <b>56</b> , and that death occurred at <b>6 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. B. Kneisley</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>148 West Washington Street 11/3/56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. B. B. Kneisley</b>		<b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-4-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov. 6. 1956</b>		24b. REGISTRAR'S SIGNATURE <b>B. B. Kneisley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES G. ROBERTSON		45		M		W		1956		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		1234		YES	
FATHER		MOTHER		BIRTH DATE		BIRTH PLACE		EDUCATION		MARRIAGE	
JAMES G. ROBERTSON		MARY G. ROBERTSON		1880		BALTIMORE, MD.		HIGH SCHOOL		MARRIED	
BROTHER		SISTER		DECEASED		DECEASED		DECEASED		DECEASED	
JAMES G. ROBERTSON		MARY G. ROBERTSON		JAMES G. ROBERTSON		MARY G. ROBERTSON		JAMES G. ROBERTSON		MARY G. ROBERTSON	

BUREAU V. S

NOV 3 1956

RECEIVED

Andrew K. Gollman, Baltimore, Md.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. E. C. HOACHLANDER  
115 W. WASH. ST.  
130 PM HAGERSTOWN MD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11871

CERTIFICATE OF DEATH

Reg. Dist. No.

118402

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>	c. LENGTH OF STAY IN 1b <u>41 YEARS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 WEST BALTIMORE ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE CLARE ROSENBERG</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER - 5 - 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 1 - 1878</u>
9. AGE (In years last birthday) <u>78-3-4</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH JACOBS</u>		14. MOTHER'S MAIDEN NAME <u>JANE ROSE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>GEORGE S. ROSENBERG FUNKSTOWN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Nov 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4 Nov</u> , 19 <u>56</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Eldon G. Hoachlander</u> M.D.		DATE SIGNED <u>ELDON G. HOACHLANDER, M.D.</u>	
PHYSICIAN'S NAME (Type) <u>115 W. WASHINGTON STREET</u>		<u>HAGERSTOWN, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>NOV. 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FUNKSTOWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>FUNKSTOWN WASH. Co. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		24. REC'D BY REGISTRAR <u>NOV. 7, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>			



11843

11844

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>645 Washington Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLAUDIA</u> Middle <u>ANNE</u> Last <u>ROWLAND</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1956</u>	
9. AGE (In years lost birthday) yrs. <u>3</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Edward L. Rowland</u>			
14. MOTHER'S MAIDEN NAME <u>Dorothy M. Williams</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Edward L. Rowland</u> Address <u>Hagerstown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGENITAL HEART DISEASE</u> DUE TO (c) <u>FROM BIRTH</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>7-28</u> , 19 <u>56</u> , to <u>11-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-16</u> , 19 <u>56</u> , and that death occurred at <u>7:05 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Margaret Sullivan</u>				DATE SIGNED <u>11-16-56</u>			
PHYSICIAN'S NAME (Type) <u>E. Margaret Sullivan, M. D.</u>				ADDRESS (Street, city or town, state) <u>314 N. Potomac St. Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				24a. REC'D BY REGISTRAR <u>11/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Brown</u>	

2081233XV4



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11844 CERTIFICATE OF DEATH

11842

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>34 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>813 The Terrace</u>				d. STREET ADDRESS <u>813 The Terrace</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		<u>GERTRUDE</u>		<u>ADAMS</u>		<u>RUDY</u>	
4. DATE OF DEATH		Month		Day		Year	
		<u>November</u>		<u>11</u>		<u>19 56</u>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>February 1, 1875</u>	<u>81</u> yrs.	Months <u>9</u>	Days <u>10</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Proprietor</u>		<u>Drug Store</u>		<u>Hagerstown, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>John U. Adams</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>H. Robert Rudy, Jr. Upper Darby, Pa.</u>			
<u>no</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>asthma</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 12</u> , 19 <u>56</u> , to <u>Dec 11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 10</u> , 19 <u>56</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>				ADDRESS (Street, city or town, state) <u>159 W. Washington St. Hagerstown, Md.</u>			
DATE SIGNED <u>11/14/56</u>							
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>				<u>159 W. Washington St., Hagerstown, Md.</u>			
22a. REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Buter-Rouzer Funeral Home</u> <u>P. Franklin Rouzer</u>				ADDRESS <u>Hagerstown, Maryland</u>		24a. REC'D BY REGISTRAR <u>200.13.1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

NOV 15 1956

RECEIVED

CERTIFICATE OF DEATH

NEWYORK STATE DEPARTMENT OF HEALTH - BALTHORE 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11843

11845 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>751 S. Potomac St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Eula</b> Middle <b>Venola</b> Last <b>Shadrach</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> , Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>dairy store</b>	9. AGE (In years lost birthday) yrs. <b>69</b>
11. BIRTHPLACE (State or foreign country) <b>near Williamsport, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Otho James</b>		14. MOTHER'S MAIDEN NAME <b>Alice C. Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-09-9963</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hematomas; pleural effusions +</b> <b>164x</b> DUE TO <b>Fibrous pericarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mechanical tumor</b> DUE TO (c) <b>(Probable Malignant Thymoma)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>1-2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 30, 1956</b> , to <b>Nov. 25, 1956</b> , that I last saw the deceased alive on <b>Nov. 24, 1956</b> , and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.		ADDRESS (Street, city or town, state) <b>217 W. Washington St., Hagerstown, Md.</b>	
DATE SIGNED <b>11/25/56</b>			
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		<b>217 W. Washington St., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-28-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov. 30, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. Bowers</b>	

BUREAU V. S.

DEC 3 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

11845

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>30 years</b>		d. STREET ADDRESS <b>1840 Jefferson Blvd</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1840 Jefferson Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Wilson</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5 1885</b>
9. AGE (In years last birthday) <b>71</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>30</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Letters Dept Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua C. Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Cronice</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-0582</b>	
17. INFORMANT <b>Mr. John Smith</b>		1840 Jefferson Blvd. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>indf.</b> INTERVAL BETWEEN ONSET AND DEATH <b>15-30 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parotid tumor of neck, right</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-16</b> , 19 <b>49</b> , to <b>11-4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11-1</b> , 19 <b></b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert Y. Keade</b> M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>11-5-56</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 7-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Alfred A. Leaf Williamsport, Md</b> ADDRESS		24a. REC'D BY REGISTRAR <b>Nov. 5, 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Bowers</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. JONES		AGE 30		SEX Male		RACE White		DATE OF BIRTH 1924		PLACE OF BIRTH Baltimore, Md.	
FATHER'S NAME JAMES J. JONES		MOTHER'S NAME JANE J. JONES		DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
OCCUPATION None		EDUCATION None		RELIGION None		MARITAL STATUS Single		PREVIOUS ILLNESS None		TREATMENT None	
DATE OF INTERVIEW 1956		INTERVIEWER J. J. JONES		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None		SIGNATURE OF PHYSICIAN None		SIGNATURE OF CORONER None	

BUREAU V. S.

NOV 2 1956

RECEIVED



## 11872 CERTIFICATE OF DEATH

11845

Reg. Dist. No. 304

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>				d. STREET ADDRESS <b>Hancock Md</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Genevieve</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>11.</b> Day <b>26</b> Year <b>19 56</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29.1884</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>27</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph H Exline</b>				14. MOTHER'S MAIDEN NAME <b>Aura Marie Spiecer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>J. Hurst Smith Hancock Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-22-2</b> DUE TO <b>Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis</b> DUE TO (c) <b>Myocarditis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocarditis</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yr</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 1955</b> to <b>Nov 26, 1956</b> , that I last saw the deceased alive on <b>Nov 24, 1956</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hancock Md.</b> DATE SIGNED <b>11/28/56</b> ACTUAL SIGNATURE <b>H. E. Fabeler MD</b> PHYSICIAN'S NAME (Type) <b>H. E. Fabeler</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11.28.56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Peters Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F. Hurst Hancock Md.</b>				24a. REC'D BY REGISTRAR DATE <b>12/1/56</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Keller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-10

Registration

Maryland

DATE

DECEASED

NAME

AGE

SEX

RACE

DATE

DECEASED

DATE

DATE

DECEASED

NAME

AGE

DATE

DECEASED

DATE

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

BUREAU V. S.

DEC 5 1956

RECEIVED

## 11847 CERTIFICATE OF DEATH

Reg. Dist. No.

11846  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>1 Week</b>				d. STREET ADDRESS <b>35 Mealey Pkwy</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>BOVEY</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9 1891</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mapleville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Bovey</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Funk</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John G. Smith 35 Mealey Pkwy Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subacute Hepatitis</b> <b>580X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4-6 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity, severe</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>2-27</b> , 19 <b>52</b> , to <b>death</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11-12</b> , 19 <b>56</b> , and that death occurred at <b>4:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>11-14-56</b>							
ACTUAL SIGNATURE <b>Robert F. Keadle</b> M.D.				PHYSICIAN'S NAME (Type) <b>Hagerstown Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/15/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Nov 15 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Frank Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 BALTIMORE STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1956 6. 10.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11847

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>	
c. LENGTH OF STAY IN 1b <b>66 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD #2</b>		d. STREET ADDRESS <b>RFD #2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Walter Layton Smith, Sr.</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1889</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maintenance electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cement Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Layton H. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Alice Miner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-10-7072</b>	
17. INFORMANT <b>Mrs. Kay Mann, Rockville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Old Posterior Myocardial Infarction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>19 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/8</b> , 19 <b>55</b> , to <b>11/1</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/31</b> , 19 <b>56</b> , and that death occurred at <b>3:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>		<b>Smithsburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>11-3-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 7 1956</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAYSON R. SMITH		35 years		Male		White		Nov. 2, 1956		Baltimore, Md.	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANCE		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
Natural		Heart Disease		Coronary Artery Disease		Physician		J. H. Smith		J. H. Smith	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE		SINGLE	
Nov. 2, 1921		Baltimore, Md.		High School		Clerical		Married		Single	
DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE		MANNER OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE	
Nov. 2, 1945		Alice M. Smith		Nov. 2, 1956		Heart Disease		Natural		Heart Disease	
DATE OF DEATH OF SPOUSE		NAME OF SPOUSE		DATE OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE		MANNER OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE	
Nov. 2, 1956		Alice M. Smith		Nov. 2, 1956		Heart Disease		Natural		Heart Disease	
DATE OF DEATH OF SPOUSE		NAME OF SPOUSE		DATE OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE		MANNER OF DEATH OF SPOUSE		CAUSE OF DEATH OF SPOUSE	
Nov. 2, 1956		Alice M. Smith		Nov. 2, 1956		Heart Disease		Natural		Heart Disease	

BUREAU V. 2

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)

MORTUARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
11848									
Reg. Dist. No. 302									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH o. COUNTY WASHINGTON		11848 MARYLAND		USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND		b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 50 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 WAKEFIELD RD.				d. STREET ADDRESS 304 WAKEFIELD RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOHN		Middle WILLIAM		Last SPANGLER		4. DATE OF DEATH Month NOVEMBER Day 15 Year 56	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/9/1901		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN S. SPANGLER				14. MOTHER'S MAIDEN NAME IDA MAE WENTLING					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219-14-8874		17. INFORMANT MRS. CLARA SPANGLER		Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) HAGERSTOWN		(County) (State)	
21. I certify that I attended the deceased from 11/15, 1956, to 11/15, 1956, that I last saw the deceased alive on 11/2, 1956, and that death occurred at 1045 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 N. Potomac St. DATE SIGNED 11/17/56 ACTUAL SIGNATURE [Signature] M.D. PHYSICIAN'S NAME (Type) [Signature]									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/18/56		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Nov. 23, 1956		24b. REGISTRAR'S SIGNATURE Phyllis Cowers	

BUREAU V. S.

1956

RECEIVED

## 11874 CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 N. Conococheague St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Eber</u> Last <u>Stumbaugh</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 29, 1892</u>	
9. AGE (In years last birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>29</u> Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Depot Letterkenny</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Frederick E. Stumbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Brumbaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-2847</u>		17. INFORMANT Address <u>Mrs. Lewis Pfeltz Williamsport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.0</u> (b) <u></u> DUE TO <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1956</u> , to <u>28 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>28 Nov</u> , 19 <u>56</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Haak</u>				ADDRESS (Street, city or town, State) <u>28 W. Potomac St. Williamsport, Md.</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HAAK M.D.</u>				DATE SIGNED <u>29 Nov 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Loef</u>				ADDRESS <u>Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 29-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11843 CERTIFICATE OF DEATH

11850  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>EDWIN</b> Last <b>SWOPE</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>21</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1902</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>	
10a. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Daniel Luther Swope</b>	
14. MOTHER'S MAIDEN NAME <b>Salome Harbaugh</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214-09-8112</b>		17. INFORMANT <b>Mrs. Herman E. Swope</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Stomach with Metastases</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>20 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>11/28</b> , 19 <b>52</b> , to <b>11/21</b> , 19 <b>56</b> , that I lost saw the deceased alive on <b>11/21</b> , 19 <b>56</b> , and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Dalton M. Welty</b> M.D. <b>998 Potomac Ave. Hagerstown, Md.</b> PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b> <b>11/21</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/24/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc., Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 23, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Powers</b>			

BUREAU

1956 9c AG

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11851  
382

11850

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>437 Mechanic Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LARRY RAY WEBBER</b>		4. DATE OF DEATH Month Day Year <b>November 10, 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1956</b>
9. AGE (In years last birthday) <b>0</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>7 6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Andrew Webber</b>		14. MOTHER'S MAIDEN NAME <b>Betty Lee Demory</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Wm.A. Webber, 437 Mechanic St. Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cor Triloculare with Biventriculare</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 11, 1956</b> , to <b>Nov 10, 1956</b> , that I last saw the deceased alive on <b>Nov. 10, 1956</b> , and that death occurred at <b>10:47</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>217 W. Washington St. 11/10/56</b>	
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto, III M.D.</b>		<b>217 W. Washington St., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/12/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Knoxville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald Eckles</b>		24a. REC'D BY REGISTRAR <b>Nov. 13, 1956</b>	
ADDRESS <b>Harpers Ferry West Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Bowers</b>	

2081293376

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11875 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Blue Ridge Summit</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bule Ridge Summit</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dispensary Fort Ritchie</b>				d. STREET ADDRESS <b>Box 33</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Allan</b> Last <b>Whealdon</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>6</b> Year <b>1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1956</b>		9. AGE (In years last birthday) <b>12</b> yrs.	IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Carlisle, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry B. Whealdon</b>				14. MOTHER'S MAIDEN NAME <b>Grace Jenkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Henry B. Whealdon</b> address <b>Blue Ridge ST.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute bronchial pneumonia</b> <b>763.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 hrs</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) <b>-</b>	(County) <b>-</b>	(State) <b>-</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>11-6-56</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/8/1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) <b>Waynesboro</b>		(State) <b>Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Goss</b>				ADDRESS <b>Waynesboro, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>NOV 8 1956</b>	

MEDICAL CERTIFICATION

2



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

NOV 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11853

11876 CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. LENGTH OF STAY IN 1b <u>40 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>826 Concord St Reeder Nursing Home</u>		d. STREET ADDRESS <u>826 CONCORD ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AGNES MISSOURI WILKINSON</u>		4. DATE OF DEATH Month Day Year <u>NOVEMBER-17-1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 22-1882</u>
9. AGE (In years last birthday) <u>74-1-25</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>TILGHMAN TOWN WASH. Co MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL KENDALL</u>		14. MOTHER'S MAIDEN NAME <u>KATE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. GLOUCLA COLMIER</u>		Address <u>526 CONCORD ST. HAGERSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>592x</u> DUE TO (c) <u>592x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year +</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>46</u> , to <u>17 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 Nov</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. F. Lusby</u>		ADDRESS (Street, city or town, state) <u>230 N. Potomac Hagerstown MD</u>	
DATE SIGNED <u>17 Nov 56</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 19, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>		ADDRESS <u>BOONSBORO MD</u>	
24a. REC'D BY REGISTRAR <u>John H. Baird</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Baird</u>	
DATE <u>Nov. 19, 1956</u>			



## 11877 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SMITHSBURG</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
c. LENGTH OF STAY IN 1b <b>6 mo.</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RT.#2 SMITHSBURG</b>				d. STREET ADDRESS <b>218 N. POTOMAC ST.</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD ALBURTUS WITMER</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 28 19 56</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/3/1871</b>	
				9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED RAILWAY POSTAL CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MILTON WITMER</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ANNE ??</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. JULIA M. WITMER HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric Carcinoma</b> DUE TO <b>151x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>Smithsburg, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>6/6</b> , 19 <b>56</b> , to <b>11/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11/28</b> , 19 <b>56</b> , and that death occurred at <b>8:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles F. Hess M.D. Smithsburg, Md. 11/30/56</b>							
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D. <b>Smithsburg, Md.</b> <b>11/30/56</b>							
PHYSICIAN'S NAME (Type) <b>Charles F. Hess M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/1/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL MASOLEUM</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Dec. 3, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Powers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		RELIGION Methodist		MARRIAGE Married		EDUCATION High School		OCCUPATION Farmer		RESIDENCE Rt. 1, Box 100, Maitland, S.C.		PLACE OF BIRTH Maitland, S.C.		DATE OF BIRTH Jan. 15, 1871		DATE OF DEATH Dec. 5, 1956		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTERED Yes		FILED Yes	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S PLACE OF BIRTH Maitland, S.C.		MOTHER'S PLACE OF BIRTH Maitland, S.C.		FATHER'S DATE OF BIRTH Jan. 1, 1845		MOTHER'S DATE OF BIRTH Mar. 1, 1848		FATHER'S DATE OF DEATH Jan. 1, 1945		MOTHER'S DATE OF DEATH Jan. 1, 1945		FATHER'S PLACE OF DEATH Maitland, S.C.		MOTHER'S PLACE OF DEATH Maitland, S.C.		FATHER'S CAUSE OF DEATH Heart Disease		MOTHER'S CAUSE OF DEATH Heart Disease		FATHER'S MANNER OF DEATH Natural		MOTHER'S MANNER OF DEATH Natural		FATHER'S CERTIFICATE NO. 12345		MOTHER'S CERTIFICATE NO. 12345	
SISTER'S NAME Mary E. Harris		BROTHER'S NAME John H. Harris		SISTER'S OCCUPATION Homemaker		BROTHER'S OCCUPATION Farmer		SISTER'S PLACE OF BIRTH Maitland, S.C.		BROTHER'S PLACE OF BIRTH Maitland, S.C.		SISTER'S DATE OF BIRTH Mar. 1, 1850		BROTHER'S DATE OF BIRTH Jan. 1, 1855		SISTER'S DATE OF DEATH Jan. 1, 1950		BROTHER'S DATE OF DEATH Jan. 1, 1950		SISTER'S PLACE OF DEATH Maitland, S.C.		BROTHER'S PLACE OF DEATH Maitland, S.C.		SISTER'S CAUSE OF DEATH Heart Disease		BROTHER'S CAUSE OF DEATH Heart Disease		SISTER'S MANNER OF DEATH Natural		BROTHER'S MANNER OF DEATH Natural		SISTER'S CERTIFICATE NO. 12345		BROTHER'S CERTIFICATE NO. 12345	
SISTER'S NAME Mary E. Harris		BROTHER'S NAME John H. Harris		SISTER'S OCCUPATION Homemaker		BROTHER'S OCCUPATION Farmer		SISTER'S PLACE OF BIRTH Maitland, S.C.		BROTHER'S PLACE OF BIRTH Maitland, S.C.		SISTER'S DATE OF BIRTH Mar. 1, 1850		BROTHER'S DATE OF BIRTH Jan. 1, 1855		SISTER'S DATE OF DEATH Jan. 1, 1950		BROTHER'S DATE OF DEATH Jan. 1, 1950		SISTER'S PLACE OF DEATH Maitland, S.C.		BROTHER'S PLACE OF DEATH Maitland, S.C.		SISTER'S CAUSE OF DEATH Heart Disease		BROTHER'S CAUSE OF DEATH Heart Disease		SISTER'S MANNER OF DEATH Natural		BROTHER'S MANNER OF DEATH Natural		SISTER'S CERTIFICATE NO. 12345		BROTHER'S CERTIFICATE NO. 12345	

RECEIVED  
DEC 5 1956  
BUREAU V. S.



## 11851 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shippensburg</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		d. STREET ADDRESS <u>S. Fayette</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Kenneth</u> Last <u>Wynkoop</u>		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-1899</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Live Stock Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Live Stock</u>	9. AGE (In years last birthday) <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Shippensburg, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Wynkoop</u>		14. MOTHER'S MAIDEN NAME <u>Susan Keefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> ✓		16. SOCIAL SECURITY NO. <u>180-261639</u>	
17. INFORMANT <u>Frank J. Wynkoop R.D. 1 Shippensburg, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416x pulmonary emboli - coronation failure</u> DUE TO <u>Chronic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>November</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 24</u> , 19 <u>56</u> , and that death occurred at <u>12:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		DATE SIGNED <u>1/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-29-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Shippensburg, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>GLADHILL Co. Middletown</u>		24a. REC'D BY REGISTRAR <u>NOV 30 1956</u>	
ADDRESS <u>136 N. Palmer</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. A. Bowyer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY		2. DEATH OF DECEASED DATE	
3. NAME OF DECEASED LAST, FIRST, MIDDLE		4. SEX M F	
5. AGE YEARS MONTHS DAYS		6. RACE W C O	
7. OCCUPATION		8. CAUSE OF DEATH IMMEDIATE	
9. CAUSE OF DEATH UNDERLYING		10. PLACE OF BIRTH STATE	
11. DATE OF BIRTH		12. DATE OF DEATH	
13. PLACE OF BIRTH		14. PLACE OF DEATH	
15. NAME OF PHYSICIAN		16. NAME OF ATTENDING NURSE	
17. NAME OF WITNESS		18. NAME OF WITNESS	
19. NAME OF WITNESS		20. NAME OF WITNESS	
21. NAME OF WITNESS		22. NAME OF WITNESS	
23. NAME OF WITNESS		24. NAME OF WITNESS	
25. NAME OF WITNESS		26. NAME OF WITNESS	
27. NAME OF WITNESS		28. NAME OF WITNESS	
29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS	
33. NAME OF WITNESS		34. NAME OF WITNESS	
35. NAME OF WITNESS		36. NAME OF WITNESS	
37. NAME OF WITNESS		38. NAME OF WITNESS	
39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS	
43. NAME OF WITNESS		44. NAME OF WITNESS	
45. NAME OF WITNESS		46. NAME OF WITNESS	
47. NAME OF WITNESS		48. NAME OF WITNESS	
49. NAME OF WITNESS		50. NAME OF WITNESS	
51. NAME OF WITNESS		52. NAME OF WITNESS	
53. NAME OF WITNESS		54. NAME OF WITNESS	
55. NAME OF WITNESS		56. NAME OF WITNESS	
57. NAME OF WITNESS		58. NAME OF WITNESS	
59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS	
63. NAME OF WITNESS		64. NAME OF WITNESS	
65. NAME OF WITNESS		66. NAME OF WITNESS	
67. NAME OF WITNESS		68. NAME OF WITNESS	
69. NAME OF WITNESS		70. NAME OF WITNESS	
71. NAME OF WITNESS		72. NAME OF WITNESS	
73. NAME OF WITNESS		74. NAME OF WITNESS	
75. NAME OF WITNESS		76. NAME OF WITNESS	
77. NAME OF WITNESS		78. NAME OF WITNESS	
79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS	
83. NAME OF WITNESS		84. NAME OF WITNESS	
85. NAME OF WITNESS		86. NAME OF WITNESS	
87. NAME OF WITNESS		88. NAME OF WITNESS	
89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS	
93. NAME OF WITNESS		94. NAME OF WITNESS	
95. NAME OF WITNESS		96. NAME OF WITNESS	
97. NAME OF WITNESS		98. NAME OF WITNESS	
99. NAME OF WITNESS		100. NAME OF WITNESS	

BUREAU V. S.

NOV 30 1956

RECEIVED

## 11852 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>B.</u> Last <u>Yeakle</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u></u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Driving</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Yeakle</u>				14. MOTHER'S MAIDEN NAME <u>Katie Rohrer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-3319</u>		17. INFORMANT <u>John Yeakle</u>		Address <u>Clear Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerulonephritis with Hypertension unknown</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>one month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. n. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Clear Spring</u>		(County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>April 24, 1956</u> to <u>Nov. 22, 1956</u> , that I last saw the deceased alive on <u>Nov. 22, 1956</u> , and that death occurred at <u>11:30 a.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u>				DATE SIGNED <u>Nov. 24, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Clear Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>				ADDRESS <u>Clear Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>Nov. 26, 1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is partially filled out with handwritten text.

BUREAU V. B.

NOV 28 1956

RECEIVED